BENT CREEK
BEHAVIORAL HEALTH SERVICES

# New Patient Checklist MINOR

***WE ARE UNABLE TO SCHEDULE SERVICES UNTIL ALL DOCUMENTATION IS COMPLETED AND RECEIVED***

**Methods for returning your packet**:

- **Fax**: (580) 922-3261
- **Email**:info@bentcreekbhs.com
- **Mail**: P.O. Box 177
  Seiling, OK 73663

## Complete The Following And Return Packet For Scheduling

- ☐ Copy Of Front And Back Of Insurance Card
- ☐ Copy Of Photo ID
- ☐ Legal Guardianship Documents (*When Applicable*)
- ☐ All Demographic Info On Page 1 Marked With ( * )
- ☐ Signatures / Dates (*Pages 1-7*)
- ☐ Screening Tools (Pages 8-13)

# Bent Creek Behavioral Health Services, PLLC

*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

***Patient Name**: _____ ***Date**: _____
First M.I. Last (Maiden)

***Address**: _____
Street City/State Zip Code County

***DoB**: _____/_____/_____ ☐ Male ☐ Female ☐ Other ***SSN#**: _____-____-_____ ***Race**: _____

***Phone**: (_____)_____-_____ ☐ Home ☐ Cell ☐ Work ☐ Other Okay To Leave Message? Yes / No

*Marital Status: ☐ Never Married ☐ Married ☐ Living as Married ☐ Divorced ☐ Widowed ☐ Other

***Parent/Guardian Name** (*If Patient Is A Minor*): _____

*Relationship To Patient:_____ *Phone: (_____)_____-_____

Referred By: ☐ Self ☐ Other _____ Reason For Referral: _____

**Requested Services:** ☐ **Individual Psychotherapy** ☐ **Family Psychotherapy** ☐ **Group Psychotherapy**
☐ **Case Management** ☐ **Individual Rehabilitation** ☐ **Group Rehabilitation**

*School (*If Patient Is A Minor*): _____ Teacher: _____

*Primary Care Physician: _____ *Phone: (____)____-_____ *City: _____

Last Time Seen By PCP (*Include At Least Month / Year*): _____

**Emergency Contact**

*Full Name: _____*Relationship: _____

Email:_____ *Phone:(_____)_____-_____

**Financial Guarantor**

*Full Name: _____*Relationship: _____

*Address: _____

*Email:_____ *Phone:(_____)_____-_____

*Financial Guarantor Signature: _____ *Date:_____

**Insurance Information**

*Insurance ID#: _____ *Insurer: _____ *Insured's SSN#: ____-____-_____

*Insured's DoB: ____/____/____ *Insured's Name (*First / Last*): _____

**Patient Signature ( *If 14+* )**: _____ **Date**: _____

**Parent / Guardian's Signature**: _____ **Date**: _____
( *If Applicable* )

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# CONSENT FOR TREATMENT SERVICES

***Patient (18+) Or Parent/Guardian Initial Below***

****CONSENT FOR TREATMENT***

_____ I voluntarily agree to treatment and services from Bent Creek BHS. I understand the reasons for this treatment and the services recommended. I have been informed of my right to obtain a copy of the Participant Orientation Manual with my rights, responsibilities, and grievance/input procedures. Furthermore, I understand that while receiving services I will conduct myself as a responsible person in order to protect myself and others from exposure to contagious or infectious diseases, such as acquired immune deficiency syndrome AIDS/HIV, hepatitis, venereal diseases, COVID-19 or any other communicable disease.

****MEDICATION MANAGEMENT***

_____ If I have prescribed medications, I will provide consent for consultation with my physician. I further understand that Bent Creek BHS does not provide medication monitoring as a service, and that I should consult my physician with all needs or concerns related to medication.

***STUDENT OBSERVATION***

_____ I give Bent Creek BHS permission to allow practicum or intern students to observe sessions.

****RECORDING SESSIONS***

_____ A Bent Creek BHS therapist may need to record sessions for purposes such as training or consulting, but will never proceed without consent from the patient. At no time can a patient record a session without written consent from Bent Creek BHS.

****DURATION***

_____ This consent for treatment ends after my discharge from services except that information necessary for payment for services provided may be provided after discharge from services.

***FOLLOW-UP APPOINTMENTS/REFERRALS***

_____ I agree to be contacted after treatment services as follow-up to learn my status, my progress in meeting my goals, my satisfaction with services, and my input about services I received. The services I receive are not dependent on my agreement for follow-up contacts.

****CONFIDENTIALITY***

_____ I understand my information is confidential. Information is not released to other agencies or persons without my written consent except under a legitimate subpoena; in a medical emergency; to meet the legal requirements of reports of abuse to children or elders; or if I present a danger to myself or others. I have received information on legal requirements and limitations of mental health confidentiality. Bent Creek BHS will comply with HIPAA, **The HIPAA Privacy Rule is composed of national regulations for the use and disclosure of Protected Health Information (PHI) in healthcare treatment, payment and operations by covered entities.**

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# CONSENT FOR TREATMENT SERVICES

***Patient (18+) Or Parent/Guardian Initial Below***

****PAYMENT SOURCE RELEASE OF INFORMATION***

_____ I understand that insurance or others paying for my treatment services may review my records or may require my provider to provide information from my patient file. I agree and hereby authorize Bent Creek Behavioral Health Services, PLLC to release any and all information requested by the agencies or parties paying for my services. I understand this specific consent for release of information ends only after third party payer claims are satisfied.

****CERTIFICATION/ACCREDITATION REVIEW***

_____ I understand that my records may be reviewed by State agencies, such as The Oklahoma Health Care Authority or ODMHSAS, certifying receipt of services and/or compliance with requirements, and/or accrediting agencies, such as The Joint Commission or ODMHSAS, verifying the quality and completeness of the services I receive.

***TRANSPORTATION***

_____ I give my permission for the staff of Bent Creek Behavioral Health Services, PLLC to provide transportation for myself or my child in order to receive services.

****LATE AND NO SHOW POLICY***

_____ I understand that **being late or not giving 24 hours notice of cancellation will result in an $80** ***No Show Fee***. A 48 hour notice is appreciated, not required. Three no shows could result in referral to another mental health provider.

****GRIEVANCE PROCEDURES***

_____ I understand that I have the right to file a grievance at anypoint if I feel that I have been treated unethically or unprofessionally.

****COST OF SERVICES***

_____ I understand my insurance will be billed for the costs of my services, and I will pay the necessary copay or coinsurance if applicable. If insurance does not cover I am responsible for the cost of services rendered by Bent Creek Behavioral Services, PLLC before the session begins. I understand past due balances of more than sixty (60) days may be sent to collections.

| | | |
|---|---|---|
| Cost of | Individual Psychotherapy Intake (55 Minutes) | $150 |
| | Individual Psychotherapy (55 Minutes) | $120 |
| | Family Psychotherapy (55 Minutes) | $120 |
| | Individual Rehabilitation 1/Week (55 Minutes) | $100 |
| | Individual Rehabilitation 2/Week (55 Minutes) | $75 |

****PATIENT RIGHTS***

_____ I have been given my patients Rights for Outpatient Services form. (*Attached at the end of this intake*)

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# CONSENT FOR TREATMENT SERVICES

***Patient (18+) Or Parent/Guardian Initial Below***

## *TELEHEALTH SERVICES*

_____ I give my consent to receive services over video conferencing, telemed via HIPAA Compliant Google Meet, if needed. I understand that the services I receive will become part of the treatment record.

## **SUBPOENAED COURT APPEARANCE*

_____ Bent Creek Behavioral Health Services, PLLC employees will attend court only after being subpoenaed by a judge, and at a rate of $1,500.00 per day.

## **COMMUNICATION EMERGENCY PROCEDURES*

_____ I understand that communication with Bent Creek Behavioral Health Services, PLLC is for scheduling, paying a bill, or other non-emergent needs. Office hours are 9:00am - 4:00pm Monday through Thursday. **In an emergency I am expected to contact 911, Suicide Prevention at 1-800-273-8255, contact 988 for mental health concerns, or go to the nearest Emergency Room.**

I understand and agree to the conditions of the consent for treatment services set forth by Bent Creek Behavioral Health Services, PLLC, dba Bent Creek Counseling.

**Patient Signature (14+)** **Date**

**Parent/Guardian Signature** **Date**

**Provider/Witness Signature** **Date**

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# Treatment Team and Services

**Patient Name**_____ **Date Completed** _____

I/We (Patient/Guardian) have actively participated in the development of my service plan and understand treatment plan goals and objectives. I/We have the following response:

_____

_____

**I/We (Agree) (Disagree) with this service plan.**

_____
Patient Signature (14+) Date

_____
Parent/Guardian Signature Date

_____
Relationship to Patient

_____
Witness Signature Date

## Treatment Team:

_____

| **Responsible MHP** | **Degree/License** | **Date** |
|---|---|---|

| **Type of Service** | **Frequency** | **Printed Staff Name/Credentials** | **Signature** | **Date** |
|---|---|---|---|---|
| Ind Psychotherapy | | | | |
| Fam Psychotherapy | | | | |
| Targeted Case Management (*Medicaid*) | | | | |
| Ind Rehabilitation (*Medicaid*) | | | | |

# *Bent Creek Behavioral Health Services, PLLC*

*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*


## AUTHORIZATION FOR USE OR DISCLOSURE

| **Patient Name:** | **Date of Birth:** |
|---|---|

**AUTHORIZATIONS:** This might be consultation(s) with your own personal physician; your teacher or school counselor; another agency that also provides services to you, or a community resource for which we act as your advocate to help you receive needed services. This authorization will remain in effect until revoked by patient or guardian.

**The information is to be provided to:**

| **Name, Title:** | |
|---|---|
| **Address:** | **Phone Number:** |

**The purpose or need for this disclosure is:**

- ❑ **Personal**
- ❑ **Legal**
- ❑ **Medical Professional**
- ❑ **Insurance**
- ❑ **School**
- ❑ **Other (Specify)**_____

**Additional Information:**

_____

_____

**LEGAL EXCEPTIONS:** Bent Creek Behavioral Health Services, PLLC complies with Federal and Oklahoma State laws requiring the reporting of abuse, neglect, and harm to children and for the reporting of abuse, neglect, harm, or exploitation of Vulnerable Adults to the Department of Human Services. We must report certain infectious, contagious, or transmissible illnesses or diseases to State authorities. We must report and act on threats to harm other persons, including reporting to law enforcement. We must report specific identifying information if a person commits a crime at or in the facility. We must honor and comply with court orders, subpoenas, and other civil or authorized investigative demands. Consent or authorization is not required when it is not required by law (as, but not limited to a court order, court ordered warrant, subpoena or summons issued by a court, grand jury, a governmental or tribal inspector general, administrative body so authorized to require production of information; civil or authorized investigative demand; Medicare conditions of participation of a health care provider in the program; statutes or regulations of law or for a government program); in a medical emergency or in a disaster or disaster relief. Consent for release of individually identifiable information is not required if a person makes threats or actions presenting a danger to him/her or others. Individually identifiable information may be released to a public health authority that is authorized by law to collect/receive such information for the purpose of preventing or controlling disease, injury, or disability.

I authorize Bent Creek Behavioral Health Services, PLLC to release and/or obtain information as specified above.

_____

**Patient Signature (14+)** **Date**

_____

**Parent/Guardian Signature** **Date**

This authorization was revoked by_____, on the date of _____.

# Bent Creek Behavioral Health Services, PLLC

*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*


## *DESIGNATION OF TREATMENT ADVOCATE*

***18+ REQUIRED | 16-17 OPTIONAL****

**Patient Name**: _____ **Date**: _____

Each person being served by a licensed mental health provider or organization has the right to name a Treatment Advocate for the following reasons: 1) Someone with whom you would like to partner with during your course of treatment and, 2) Someone you trust and whose advice you value, such as a family member, spouse/partner, friend or representative from an advocacy organization. You have the right to set limits regarding the level of involvement of the person you select and you have the right to change or revoke your selection at any time. You also have the right to not name a Treatment Advocate. Should you name a Treatment Advocate, this person must agree to serve and to adhere with all standards of confidentiality.

**Treatment Advocate Election**

_____ Yes, I wish to name a Treatment Advocate.

_____ No, I do not wish to name a Treatment Advocate at this time. However, I may elect to do so at any time in the future

**If yes, please identify that person now. As designated Treatment Advocate we will make contact and inform them of their designation.**

Full Name: _____

Phone:_____

Address: _____

_____

Patient Signature (14+) Date

_____

Parent/Guardian Signature Date

_____

Treatment Advocate Signature Date

_____

**Provider/Witness Signature** **Date**

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# PRESENTING PROBLEMS AND CONCERNS

**Describe the problem that brought you here today:**

_____

_____

_____

**Please check all of the behaviors and symptoms that you consider problematic:**

- ❑ Distractibility
- ❑ Hyperactivity
- ❑ Impulsivity
- ❑ Boredom
- ❑ Poor memory/confusion
- ❑ Seasonal mood changes
- ❑ Sadness/depression
- ❑ Loss of pleasure/interest
- ❑ Hopelessness
- ❑ Thoughts of death
- ❑ Self-harm behaviors
- ❑ Crying spells
- ❑ Loneliness
- ❑ Low self worth
- ❑ Guilt/shame
- ❑ Fatigue
- ❑ Change in appetite
- ❑ Lack of motivation
- ❑ Withdrawal from people
- ❑ Anxiety/worry
- ❑ panic attacks
- ❑ Fear away from home
- ❑ Social discomfort
- ❑ Obsessive thoughts
- ❑ Compulsive behavior
- ❑ Aggression/fights
- ❑ Frequent arguments
- ❑ Irritability/anger
- ❑ Homicidal thoughts
- ❑ Flashbacks
- ❑ Hearing voices
- ❑ Visual hallucinations
- ❑ Suspicion/paranoia
- ❑ Racing thoughts
- ❑ Excessive energy
- ❑ Wide mood swings
- ❑ Sleep problems
- ❑ Nightmares
- ❑ Eating problems
- ❑ Gambling problems
- ❑ Computer addiction
- ❑ Problem with porn
- ❑ Parenting problems
- ❑ Sexual problems
- ❑ Relationship problems
- ❑ Work/School problems
- ❑ Alcohol/drug use
- ❑ Disturbing memories

**Are your problems affecting any of the following?**

- ❑ Handling everyday tasks
- ❑ Work/school
- ❑ Recreational activities
- ❑ Self esteem
- ❑ Housing
- ❑ Sexual activity
- ❑ Relationships
- ❑ Legal matters
- ❑ Health
- ❑ Hygiene
- ❑ Finances

□ **Yes** □ **No** Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe**:**

_____

_____

□ **Yes** □ **No** Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe**:**

_____

_____

□ **Yes** □ **No** Have you gambled in the past 6 months? If yes, let us know the following**:**
□ **Yes** □ **No** Have you ever felt the need to bet more money than you had**?**
□ **Yes** □ **No** Have you ever had to lie to people important to you about gambling**?**

# Bent Creek Behavioral Health Services, PLLC

*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*


## PHYSICAL/MEDICAL HEALTH SCREENING

1. Are you being seen by a medical provider?
   o Yes o No
   a. If yes, who?
   _____
   b. Date of last physical exam:_____
2. Do you have any current health issues? o Yes o No If yes, please briefly describe:
   _____
   _____
3. Do you have any past health issues? o Yes o No If yes, please briefly describe:
   _____
   _____
4. Would you be interested in receiving assistance to make an appointment with a medical provider? o Yes o No
5. Do you have any physical symptoms (e.g., pain, tiredness, weakness, physical discomfort, etc.) that either you or others are concerned about?
   o Yes o No If yes, please briefly describe:
   _____
   _____
6. Do you have any other physical concerns that you'd like to note?
   o Yes o No If yes, please briefly describe:
   _____
7. Are there any stressors in your life (e.g., financial pressure, work stress, family conflicts) that are affecting your health/mental health?
   o Yes o No If yes, please briefly describe:
   _____
   _____
8. Do you smoke tobacco or THC? o Yes o No
9. Have you or are you currently dieting? o Yes o No
10. Do you drink alcoholic beverages? o Yes o No
    If yes, what is your approximate intake of these beverages weekly?
    _____

## Present Medical History

Check those questions to which you have issues with (leave others blank).

- ❑ Blood pressure
- ❑ Pain in your chest
- ❑ Rapid heart beat
- ❑ Difficulty breathing
- ❑ Increased anxiety or depression
- ❑ Problems with recurring fatigue
- ❑ Trouble sleeping
- ❑ Irritability
- ❑ Migraine or headaches
- ❑ Stomach or intestinal problems
- ❑ Significant vision or hearing problems
- ❑ Significant unexplained weight loss/gain
- ❑ Current or past issue with cancer

**If more information is needed please attach an additional page.**

## Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ❑ Heart attack-If so, Date:_____
- ❑ Arthritis of legs or arms
- ❑ Diabetes or abnormal blood-sugar tests
- ❑ Dizziness or fainting spells
- ❑ Epilepsy or seizures
- ❑ Stroke
- ❑ Nervous or emotional problems
- ❑ Anemia
- ❑ Thyroid problems
- ❑ Asthma
- ❑ Other lung disease
- ❑ Injuries to back, arms, legs or joint
- ❑ Broken bones

**Do you have any other health concerns that we need to discuss?**

_____
_____
_____
_____

**Allergies:**

_____
_____
_____
_____

**Current medication list:**

_____
_____
_____
_____

# Bent Creek Behavioral Health Services, PLLC

*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*


Patient Name:_____ Date: _____

**PLEASE COMPLETE THE PHQ-9 AND GAD-7**

Patient Name: DOB: Date of Referral:

| **PHQ9**<br>**Over the last two weeks how often have you been bothered by the following problems?** | | **0**<br>Not at all | **1**<br>Several Days | **2**<br>More than half the days | **3**<br>Nearly every day |
|---|---|---|---|---|---|
| A | Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| B | Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| C | Trouble falling or staying asleep, sleeping too much | ☐ | ☐ | ☐ | ☐ |
| D | Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| E | Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| F | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| G | Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| H | Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| I | Thoughts that you would be better off dead or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |
| Severity Score | Mild depression = 5 – 10<br>Moderate depression = 10 – 18<br>Severe depression = 19 – 27 | Total Score: | | | |
| | If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

| **GAD7**<br>**Over the last two weeks how often have you been bothered by the following problems?** | **0**<br>Not at all | **1**<br>Several Days | **2**<br>Over than half the days | **3**<br>Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ | ☐ | ☐ | ☐ |
| Not being able to stop or control worrying | ☐ | ☐ | ☐ | ☐ |
| Worrying too much about different things | ☐ | ☐ | ☐ | ☐ |
| Trouble relaxing | ☐ | ☐ | ☐ | ☐ |
| Being so restless that it's hard to sit still | ☐ | ☐ | ☐ | ☐ |
| Becoming easily annoyed or irritable | ☐ | ☐ | ☐ | ☐ |
| Feeling afraid as if something awful might happen | ☐ | ☐ | ☐ | ☐ |
| Total Score (add your column scores) | | | | |
| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

# Bent Creek Behavioral Health Services, PLLC

*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*


Patient Name:_____ Date: _____

## SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

### Step 1: Identify Risk Factors

| C-SSRS Suicidal Ideation Severity | Month |
|---|---|
| **1) Wish to be dead**<br>*Have you wished you were dead or wished you could go to sleep and not wake up?* | |
| **2) Current suicidal thoughts**<br>*Have you actually had any thoughts of killing yourself?* | |
| **3) Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act)<br>*Have you been thinking about how you might do this?* | |
| **4) Suicidal Intent without Specific Plan**<br>*Have you had these thoughts and had some intention of acting on them?* | |
| **5) Intent with Plan**<br>*Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?* | |
| **C-SSRS Suicidal Behavior:** *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br>If "YES" Was it within the past 3 months? | **Lifetime**<br><br>**Past 3 Months** |

**Activating Events:**
- □ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- □ Pending incarceration or homelessness
- □ Current or pending isolation or feeling alone

**Treatment History:**
- □ Previous psychiatric diagnosis and treatments
- □ Hopeless or dissatisfied with treatment
- □ Non-compliant with treatment
- □ Not receiving treatment
- □ Insomnia

**Other:**
- □ _____
- □ _____
- □ _____

**Clinical Status:**
- □ Hopelessness
- □ Major depressive episode
- □ Mixed affect episode (e.g. Bipolar)
- □ Command Hallucinations to hurt self
- □ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- □ Highly impulsive behavior
- □ Substance abuse or dependence
- □ Agitation or severe anxiety
- □ Perceived burden on family or others
- □ Homicidal Ideation
- □ Aggressive behavior towards others
- □ Refuses or feels unable to agree to safety plan
- □ Sexual abuse (lifetime)
- □ Family history of suicide

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

Patient Name:_____ Date: _____

## Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

*Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."*

**PART 1:**

1. Has your child ever lived with a parent/caregiver who went to jail/prison?
2. Do you think your child ever felt unsupported, unloved and/or unprotected?
3. Has your child ever lived with a parent/caregiver who had mental health issues?
   *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Has your child ever lacked appropriate care by any caregiver?
   *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?

   Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child?

   Or has any adult in the household ever hit your child so hard that your child had marks or was injured?

   Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?
9. Has your child ever experienced sexual abuse?
   *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)?
    *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*

Total Yes:_____

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

| PART 2: |
|---|
| 1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)* |
| 2. Has your child experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)* |
| 3. Has your child ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)* |
| 4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more? |
| 5. Has your child ever been separated from their parent or caregiver due to foster care, or immigration? |
| 6. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability? |
| 7. Has your child ever lived with a parent or caregiver who died? |

Total Yes:_____

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# PATIENT RIGHTS FOR OUTPATIENT SERVICES

All patients receiving outpatient services shall have and enjoy all constitutional and statutory rights of all citizens of the State of Oklahoma and the United States, unless abridged through the due process of law by a court of competent jurisdiction. Each facility by, or certified by, or under contract with DMHSAS providing outpatient mental health and/or substance abuse services shall insure patients have the rights specified as follows:

(1) Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
(2) Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
(3) No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.
(4) Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. Additionally, each consumer shall have the right to the following:

(A) Allow other individuals of the consumer's choice to participate in the consumer's treatment and with the consumer's consent;
(B) To be free from unnecessary, inappropriate, or excessive treatment;
(C) To participate in consumer's own treatment planning;
(D) To receive treatment for co-occurring disorders if present;
(E) To not be subject to unnecessary, inappropriate, or unsafe termination from treatment; and
(F) To not be discharged for displaying symptoms of the consumer's disorder.

(5) Every consumer's record shall be treated in a confidential manner.
(6) No consumer shall be required to participate in any research project or medical experiments without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
(7) A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
(8) Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
(9) No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.
(10) All adult mental health consumers being served by a licensed mental health professional shall be informed by the LMHP or the mental health treatment facility that the consumer has the right to designate a family member or other concerned individual as a treatment advocate.

(a) The consumer shall not be coerced, directly or indirectly, into naming or not naming a Treatment Advocate or choice of Treatment Advocate or level of involvement of the Treatment Advocate. Any individual so designated shall at all times act in the best interests of the consumer and comply with all conditions of confidentiality.
(b) No limitation may be imposed on a consumer's right to communicate by phone, mail or visitation with his or her Treatment Advocate, except to the extent that reasonable times and places may be established.
(c) The Treatment Advocate may participate in the treatment planning and discharge planning of the person being served to the extent consent to by the consumer and permitted by law.
(d) The consumer and Treatment Advocate shall be notified of treatment and discharge planning meetings at least 24 hours in advance.
(e) The consumer may change or revoke the designation of a treatment advocate at any time and for any reason.
(f) A copy of the completed form shall be given to the consumer and the treatment advocate. The original shall be maintained in the consumer's record.
(g) The Treatment Advocate form shall be reviewed with the consumer at each point of treatment planning and treatment planning review to afford the consumer an opportunity for review and amendment.

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# CONSENT FOR TREATMENT SERVICES

***CONSENT FOR TREATMENT*:** I voluntarily agree to treatment and services from Bent Creek BHS. I understand the reasons for this treatment and the services recommended. I have been informed of my right to obtain a copy of the Participant Orientation Manual with my rights, responsibilities, and grievance/input procedures. Furthermore, I understand that while receiving services I will conduct myself as a responsible person in order to protect myself and others from exposure to contagious or infectious diseases, such as acquired immune deficiency syndrome AIDS/HIV, hepatitis, venereal diseases, COVID-19 or any other communicable disease.
***MEDICATION MANAGEMENT*:** If I have prescribed medications, I will provide consent for consultation with my physician. I further understand that Bent Creek BHS does not provide medication monitoring as a service, and that I should consult my physician with all needs or concerns related to medication.
***STUDENT OBSERVATION*:** I give Bent Creek BHS permission to allow practicum or intern students to observe sessions.
***RECORDING SESSIONS*:** A Bent Creek BHS therapist may need to record sessions for purposes such as training or consulting, but will never proceed without consent from the patient. At no time can a patient record a session without written consent from Bent Creek BHS.
***DURATION*:** This consent for treatment ends after my discharge from services except that information necessary for payment for services provided may be provided after discharge from services.
***FOLLOW-UP APPOINTMENTS/REFERRALS*:** I agree to be contacted after treatment services as follow-up to learn my status, my progress in meeting my goals, my satisfaction with services, and my input about services I received. The services I receive are not dependent on my agreement for follow-up contacts.
***CONFIDENTIALITY*:** I understand my information is confidential. Information is not released to other agencies or persons without my written consent except under a legitimate subpoena; in a medical emergency; to meet the legal requirements of reports of abuse to children or elders; or if I present a danger to myself or others. I have received information on legal requirements and limitations of mental health confidentiality. Bent Creek BHS will comply with HIPAA, **The HIPAA Privacy Rule is composed of national regulations for the use and disclosure of Protected Health Information (PHI) in healthcare treatment, payment and operations by covered entities.**
***PAYMENT SOURCE RELEASE OF INFORMATION*:** I understand that insurance or others paying for my treatment services may review my records or may require my provider to provide information from my patient file. I agree and hereby authorize Bent Creek Behavioral Health Services, PLLC to release any and all information requested by the agencies or parties paying for my services. I understand this specific consent for release of information ends only after third party payer claims are satisfied.
***CERTIFICATION/ACCREDITATION REVIEW*:** I understand that my records may be reviewed by State agencies, such as The Oklahoma Health Care Authority or ODMHSAS, certifying receipt of services and/or compliance with requirements, and/or accrediting agencies, such as The Joint Commission or ODMHSAS, verifying the quality and completeness of the services I receive.

***TRANSPORTATION*:** I give my permission for the staff of Bent Creek Behavioral Health Services, PLLC to provide transportation for myself or my child in order to receive services.
****LATE AND NO SHOW POLICY*:** I understand that **being late or not giving 24 hours notice of cancellation will result in an $80 *No Show Fee*.** A 48 hour notice is appreciated, not required. Three no shows could result in referral to another mental health provider.
****GRIEVANCE PROCEDURES*:** I understand that I have the right to file a grievance at anypoint if I feel that I have been treated unethically or unprofessionally.
****COST OF SERVICES*:** I understand my insurance will be billed for the costs of my services, and I will pay the necessary copay or coinsurance if applicable. If insurance does not cover I am responsible for the cost of services rendered by Bent Creek Behavioral Services, PLLC before the session begins.

| | | |
|---|---|---|
| Cost of | Individual Psychotherapy Intake (55 Minutes) | $150 |
| | Individual Psychotherapy (55 Minutes) | $120 |
| | Family Psychotherapy (55 Minutes) $120 | |
| | Individual Rehabilitation 1/Week (55 Minutes) | $100 |
| | Individual Rehabilitation 2/Week (55 Minutes) | $75 |

****PATIENT RIGHTS*:** I have been given my patients Rights for Outpatient Services form. (*Attached at the end of this intake*)
***TELEHEALTH SERVICES*:** I give my consent to receive services over video conferencing, telemed via HIPAA Compliant Google Meet, if needed. I understand that the services I receive will become part of the treatment record.
****SUBPOENAED COURT APPEARANCE*:** Bent Creek Behavioral Health Services, PLLC employees will attend court only after being subpoenaed by a judge, and at a rate of $1,500.00 per day.
****COMMUNICATION EMERGENCY PROCEDURES*:** I understand that communication with Bent Creek Behavioral Health Services, PLLC is for scheduling, paying a bill, or other non-emergent needs. Office hours are 9:00am - 4:00pm Monday through Thursday. **In an emergency I am expected to contact 911, Suicide Prevention at 1-800-273-8255, contact 988 for mental health concerns, or go to the nearest Emergency Room.**
***CONTACT:*** We may call or contact you or the person you designate as "always knows where you will be" with information about appointments, other services you might be interested in, and to receive follow along or follow up information on "how you are doing". (As, during times when services are interrupted by holidays or vacations) You have the right to accept or refuse these contacts. Services you receive continue whether or not you accept contacts.
***PAYMENT:*** Individually identifiable information considered protected health information may be disclosed for use in determination of eligibility by the Oklahoma Health Care Authority; for payment activities as claim processing, billing information sent to and required by OHCA for Medicaid reimbursements. This information may contain individually identifiable information (name, address, age, claim number, etc.). Information is electronically sent with a fax cover for security and confidentiality.
***HEALTH CARE OPERATIONS:*** We are required to meet certain certification, contracting, and accreditation requirements. Persons providing these reviews sign agreements as business associates to assure that they too follow the requirements of privacy and confidentiality of your information.

***SECURITY:*** We protect your personal information in a safe place, with locked and monitored access only by people who have the right to know (your treatment team, persons employed or under contract; our Quality Assurance program, auditors and reviewers from OHCA, or certifying agencies). We use safeguards on our computers and electronic equipment. We do not use your personally identifiable information in email communications. Accounting and related functions use only a number code which does not identify you as a person.

***LEGAL EXCEPTIONS:*** We comply with Federal and Oklahoma State laws requiring the reporting of abuse, neglect, and harm to children and for the reporting of abuse, neglect, harm, or exploitation of Vulnerable Adults to the Department of Human Services. We must report certain infectious, contagious, or transmissible illnesses or diseases to State authorities. We must report and act on threats to harm other persons, including reporting to law enforcement. We must report specific identifying information if a person commits a crime at or in the facility. We must honor and comply with court orders, subpoenas, and other civil or authorized investigative demands. Consent or authorization is not required when it is not required by law (as, but not limited to a court order, court ordered warrant, subpoena or summons issued by a court, grand jury, a governmental or tribal inspector general, administrative body so authorized to require production of information; civil or authorized investigative demand; Medicare conditions of participation of a health care provider in the program; statutes or regulations of law or for a government program); in a medical emergency or in a disaster or disaster relief. Consent for release of individually identifiable information is not required if a person makes threats or actions presenting a danger to him/her or others. Individually identifiable information may be released to a public health authority that is authorized by law to collect/receive such information for the purpose of preventing or controlling disease, injury, or disability.

***AUTHORIZATIONS:*** We ask you or your personal representative to authorize other releases, uses, or disclosures of information about you as these may become necessary. This might be consultation(s) with your own personal physician; your teacher or school counselor; another agency that also provides services to you, or a community resource for which we act as your advocate to help you receive needed services. You may revoke an authorization given, at any time, except that actions taken while the authorization was in effect are not changed. You are asked to revoke or cancel this authorization in writing.

***YOUR PRIVACY RIGHTS:*** You have the right to request restrictions on certain uses and disclosures of protected health information. You have the right to request confidential communications. You have the right to request a written list or “accounting” of disclosures of your protected health information. You have the right of access; to review with your therapist or counselor the contents of your protected health information. You have the right to amend or make corrections to that record. If we disagree and believe the record is incorrect, we will still attach your amendment to it. You have the right to make a complaint or grievance or to make suggestions and recommendations. The grievance and complaint procedures are posted for your use. Bent Creek Behavioral Health Services, PLLC reserves the right to make changes or modifications to its practices, and to make changes or modifications of its policies and procedures as required by changes in law or regulation. Changes in policy or procedures will be made available to you by posted Notice, with a copy given to you within 60 days of any material revision.

**Any additional questions, comments, or concerns about patient care can be directed to the main office of Bent Creek BHS at:** PO Box 177 Seiling, OK 73663 (580) 922-5656

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

This consent for Treatment, Payment, and Healthcare Operations is granted to:

Bent Creek Behavioral Health Services, PLLC
PO Box 177
Seiling, Ok 73663

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations" (for example, quality improvement activities, confirming a referral, follow-up or follow along contacts, contacts for appointment or schedule information, surveys or audits by accrediting, certifying, or monitoring organizations to verify services received and our compliances with requirements, and meeting of your treatment team for treatment plan development, review, update or revision, or internal coordination of services).We ask you to make your permission for these uses very clear. ***By signing consent, you voluntarily agree that we may use or disclose your protected health information for treatment, obtaining payment for services, and for professional operations.***

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review this notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the lobby and hall area. You may ask for a printed copy of our Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. We may not be able to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

This consent will end automatically one hundred and eighty days (180) after you discharge from services. This is to allow time for quality/effectiveness follow-up contacts with you. You may revoke this consent at any time by giving us written notification. Revoking the consent will not affect any action we took earlier in reliance on this consent before the revocation.

You may refuse to sign this voluntary consent. We are permitted to refuse to provide health care services if this consent is not granted or is later revoked.

Your personal information is confidential and protected. We pay close attention to the privacy and confidentiality of information about you under Federal and State law and under our professional code of ethics. This consent does not apply to releases of information to external agencies or personnel requiring your written authorization with some exceptions (please see Notice of Privacy Practices for details of exceptions and substance abuse confidentiality).

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# GRIEVANCE PROCEDURES

**PROCEDURES FOR PATIENT GRIEVANCES AND OTHER ISSUES:** Bent Creek Behavioral Health Services, PLLC wishes to maintain an open line of communication, giving the patient adequate opportunity to express opinions, recommendations, and complaints.

**WHO MAY FILE A GRIEVANCE:** Any patient under the care of Bent Creek Behavioral Health Services, PLLC or anyone interested in the welfare of a patient receiving care at Bent Creek Behavioral Health Services, PLLC (e.g. relative, foster parent, DHS Caseworker) may at his/her discretion provide in writing any opinion or recommendation.

**WHAT COMPLAINTS ARE CONSIDERED:** The complaint may be about any rule, policy, action, decision, or condition made or permitted by Bent Creek Behavioral Health Services, PLLC.

**WHEN A GRIEVANCE MAY BE FILED:** It is important that grievances be filed as soon as possible. Grievances should be filed within five days of the action grieved.

**HOW TO FILE A GRIEVANCE:** Request a Grievance Form and write your complaint on the form including your ideas and a resolution to the problem. Sign the form and return it to the Grievance Coordinator or the Program Director. You may request assistance from Bent Creek Behavioral Health Services, PLLC writing and/or filing the grievance.

The patient may request a written report from the committee, which shall be provided within thirty days from filing of the grievance or complaint. After your grievance is filed, an attempt will be made, with your participation, to resolve the problem. **You have the right to file grievances, to receive a written response to your complaint, and to appeal if you are not satisfied with the response. If any person attempts to deny you these rights or penalize you for filing a grievance, contact the Program Director.**

**TO FURTHER PURSUE A GRIEVANCE:**

Advocacy Office
900 East Main Street
P.O. Box 151
Norman, OK 73070
Phone: (405) 573-6605

The Joint Commission
Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Phone: 1 (800) 994-6610

For more information about Grievance Procedures, contact the Director of Bent Creek Behavioral Health Services, PLLC.

***Zachery Helterbrake, M.C.P., LPC***
***(580) 922-5656***
***info@bentcreekbhs.com***

**Bent Creek Behavioral Health Services, PLLC**
*Office: (580) 922-5656 | Fax: (580) 922-3261 | Email: info@bentcreekbhs.com*

# INFORMED CONSENT ADDENDUM FOR TELEHEALTH SERVICES

Telehealth is the practice of providing psychotherapy (or other medical services) using technology-assisted means that allows interactive audio and video capabilities without the patient and therapist being in the same physical location. Such services may include, but are not limited to, assessment, diagnosis, and treatment. Conducting therapy via telehealth is similar to using video-conferencing capabilities to conduct virtual meetings.

## Risks and Benefits of Telehealth

In addition to the risks, benefits, and other information we have discussed regarding therapy, there is some information that is unique to conducting therapy via telehealth. Benefits of telehealth include the flexibility and convenience of being able to conduct sessions from your home, office, or nearly any other private location, which can increase access to services. Risks for telehealth include: (1) disruption or distortion of sessions due to technological difficulties, (2) privacy limitations that are beyond my control, but may be within your control such as other individuals that may be in close proximity to you during our session who may overhear parts of our session, and (3) potential limitations on my ability to utilize non-verbal cues or other environmental information in assessment and treatment. It is also important to understand that telehealth is not appropriate for all patients and situations. If at any point I determine that telehealth is not clinically indicated for your situation, I will discuss with you other options and provide appropriate referrals as needed.

## Fees for Telehealth Sessions

My fees for telehealth sessions are the same as my fees for in-person sessions and are set forth in my fee agreement. Telehealth sessions may or may not be covered by your insurance company to the same extent that in-person sessions are covered. It is your responsibility to contact your insurance company to determine whether your policy reimburses for telehealth sessions.

## Emergencies

When providing services via telehealth, it is important for me to have some additional information from you in case of an emergency. At the beginning of each session, I will request the physical address of your current location. This information is necessary so that I can request appropriate assistance in the case of a medical or mental health emergency. In the event of a clinical emergency (medical or mental health), I will contact appropriate law enforcement and/or medical services to render aid