Crosspointe Family Services--Patient Demographics
Please fill out front and back of Form.

Patient Information

Last Name: ______ First: ______ Middle: ______

Street Address: ______

City: ______ State: ______ Zip: ______ Cell Phone: ______

Soc. Sec. #: ______ Date of Birth: ______ Age: ______ Sex: **M F**

E-mail: Marital Status:

Custodian/Guardian Information FOR YOUTH 18 or Younger

Who does the client live with? Name: ______

Address: ______ Phone: ______

Does this person have the legal authority to consent for treatment? Yes No

If Yes, circle one: Biological/Adoptive Parent Legal Guardian Foster Parent IDHW Caseworker

If No, who has this authority? Name ______ Phone: ______

Address: ______ **City:** ______ **State:** ______ **Zip:** ______

****We are unable to see a youth client without the consent of the legal parent/guardian/custodian.**

Other Information

Occupation: ______

Employer: ______

Employer Address: ______

Work Phone:

Referring Source: ______

What are we seeing you for? ______

Preferred Language: ______

Communication Needs: ______

Spouse:

Race: Circle Answers	**Ethnicity:**
1 American Indian/Alaskan Native	1 Hispanic
2 Asian	2 Non-Hispanic
3 Black or African American	
4 Native Hawaiin/ Pacific Islander	
5 White or Caucasian	
6 Prefer not to answer	

Responsible Party Information

Responsible Party: ______ D.O.B. ______ Soc. Sec. #: ______

Address: ______ Phone: ______

Relationship: ______ Occupation: ______

Employer: ______ Work Phone: ______

Insurance Information

Policy Holder: ______ D.O.B. ______

Medical Insurance: ______

Address: ______ Phone: ______

City: ______ State: ______ Zip: ______ E-mail: ______

Policy #: ______ Medicaid #: ______

Group #: ______ Medicare # ______

Emergency Information	IN CASE OF EMERGENCY CONTACT (Person NOT LIVING with patient).							
	Contact Name:				Relationship to Patient:			
	Address:						Phone:	
	City:		State:		Zip:		Cell Phone:	

Insurance payments are considered a method of reimbursment to the insured participant for fees paid to Crosspointe and is not a substitute for payment. We do not accept this amount as "payment in full" (unless otherwise restricted by law or agreement with your insurer). IN ORDER TO MAINTAIN COSTS WE ASK THAT OUR CHARGES AND COPAYS BE PAID AT THE TIME OF EACH VISIT. In the event the account is turned over for collection, you agree to pay all collection fees and/or legal fees including attorney fees.

I hereby assign all medical and mental health benefits to which I'm entitled including Medicaid, Medicare, private insurance and other health plans to Crosspointe Family Services. This assignment will remain in effect until revoked by me. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment for services I recieved via Facsimile, hard copy, or electronically.

Patient Signature: ______________________ **Date:** __________

Guardian Signature: ______________________ **Date:** __________

Form A 10 2018

ACKNOWLEDGEMENT

I acknowledge that I have read, reviewed, and was offered a copy of the following Crosspointe Terms and Conditions for Treatment.

1. Notice of Privacy Practices
2. Informed Consent for Treatment
3. Participants Rights and Grievance Procedure
4. Patient Authorization for Third Party Payor Reimbursement of Provider and Other Verification
5. Other Terms and Conditions

Patient Name: ____

Patient Signature: ________________________________ Date: __________

Parent/Guardian Name: ____

Parent/Guardian Signature: ______________________ Date: __________

Agency Witness: ____

07/2018

Office: 208.736.7090 | Medical Fax: 208.933-2188 BH Fax 208-736-7089 | 1363 Fillmore St., Twin Falls, ID 83301 | www.crosspointefamilyservices.com

Patient Name: ____________ **Date:** ____________ **Birthdate:** ____________

List all **ALLERGIES** you have: ____________

List all **MEDICATIONS** you take: ____________

List all Herbal **Supplements** and **Vitamins** you take: ____________

List any previous significant **TRAUMA**: ____________

Indicate any **SURGERIES** you have had:

- [ ] Appendix
- [ ] Hernia
- [ ] Uterus
- [ ] Heart
- [ ] Gallbladder
- [ ] Tonsils
- [ ] Tubes Tied
- [ ] None
- [ ] List Other: ____________

Do **You** have any of the the following medical problems?

- [ ] Asthma/Lung
- [ ] Arthritis
- [ ] AIDS
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Heart
- [ ] Stroke
- [ ] Cancer
- [ ] Depression
- [ ] Mood swings
- [ ] HIV
- [ ] List other: ____________

Do any of the following Medical problems run in your **FAMILY**?

- [ ] Asthma/Lung
- [ ] Arthritis
- [ ] Psychiatric
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Heart
- [ ] Stroke
- [ ] Cancer
- [ ] List Other: ____________

Do you Smoke? [ ] Yes [ ] No

Packs per day? ______ Years? ______

Do you drink Alcohol [ ] Yes [ ] No

Type and Number of drinks per day ____________

Do You now or have you ever used or taken any drugs not prescribed by a doctor?

- [ ] No
- [ ] Yes Please list: ____________

Do You use smokless tobbaco/chew? [ ] Yes [ ] No

Form H 8/14

Check any you have had recently or concerns:

- [ ] Low Energy Level
- [ ] Excessive Sleeping
- [ ] Excessive Energy
- [ ] Weakness
- [ ] Restlessness
- [ ] Recent Vision Changes
- [ ] Excessive Sadness
- [ ] Trembling/Shaking
- [ ] Irritability
- [ ] Shortness of breath
- [ ] Chest Pain
- [ ] Difficulty breathing
- [ ] Comunicable Disease
- [ ] Over Use of Laxatives
- [ ] Nausea
- [ ] Aggression
- [ ] Vomiting
- [ ] Easily Distracted
- [ ] Diarrhea
- [ ] Itching
- [ ] Victim of Crime
- [ ] Hair Pulling
- [ ] Excessive Anger
- [ ] Fainting
- [ ] Self Injury
- [ ] Seizures
- [ ] Headache
- [ ] Insomnia
- [ ] Dizziness
- [ ] Anxiety
- [ ] Numbness
- [ ] Suicidal Thoughts
- [ ] Depression
- [ ] Nightmares
- [ ] Hallucinations
- [ ] Excessive Worry
- [ ] Mood Swings
- [ ] Panic
- [ ] Excessive Hunger
- [ ] Unexplained Pain
- [ ] Weight Gain
- [ ] Weight Loss
- [ ] Heartburn
- [ ] Change of Libido
- [ ] # of Pregancies:
- [ ] # of Children:

Who is your primary care doctor/provider?

____

When was your last vist with your primary provider?

____

Who else manages your medical and/or behavioral health care: Provider Name/City

____

Comments:

____

At Crosspointe Family Services we want to ensure that we are coordinating your care with all of your providers. Please tell us who is involved in your medical and behavioral health care. We believe that working together as a care team on your behalf provides the greatest care to you.

Patient's Name ______________________ **B-Day** ______________

Provider Name ______________________ Specialty ______________

Facility Name ______________________ City ________________

Provider Name ______________________ Specialty ______________

Facility Name ______________________ City ________________

Provider Name ______________________ Specialty ______________

Facility Name ______________________ City ________________

Provider Name ______________________ Specialty ______________

Facility Name ______________________ City ________________

Thank you for your help!

If you have any questions or concerns about how we coordinate your care or how we use the information please contact:

Mark Gritton
208-736-7090

We respect and protect your patient rights.

Office: 208.736.7090 | Medical Fax: 208.933-2188 BH Fax 208-736-7089 | 1363 Fillmore St., Twin Falls, ID 83301 | www.crosspointefamilyservices.com

Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

MEDICAL-Release and/or Exchange of Protected Health Information

Patient Name: ______________________ Date of Birth: ______________________

Parent/Guardian/Foster Parent Name: ______________________

I DECLINE TO RELEASE ANY INFORMATION TO: ______________________

I authorize:

Name/Title: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ________

Phone: (   ) ______________ Fax: (   ) ______________

(Initial either or both as needed.) ____ **to release PHI information to:** ___**to obtain PHI information from:**

Crosspointe Family Services
1363 Fillmore St
Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

A. The confidential Protected Health Information (PHI) to be released: (Initial)

___History and Physical
___Last Office Progress Note
___Progress Notes: from_____ to _____
___Discharge Summary
___Laboratory Results
___Pharmacy/Medication List
___Medication List(s)
___Comprehensive Diagnostic Assessment
___Coordination of Care Communication
___Entire Medical Record
___Parent/Guardian Communication
___Care Plan
___Other: ______________________

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

B. Effective date of authorization:

This authorization takes effect the day that you sign it and terminates on: ____________ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

______________________ ______________________

Participant/Guardian/Foster Signature Date Witness Signature Date

NO SHOW/MISSED APPOINTMENT POLICY

Definitions:

No Call/No Show: ***ANY*** *missed appointment that isn't canceled with at least 24 hours' notice.*

- If you call the day of your appointment, it is considered a No Call/No Show.
- If you do not show up for your appointment, it is considered a No Call/No Show.
- If you are more than 10 minutes late for your appointment, it is considered a No Call/No Show.

Adequate Communication: *Calling AT LEAST 24 hours in advance to cancel or change an appointment.*

- When you call with at least 24 hours' notice, we are able to allow another client to fill your appointment.

Emergency: An emergency is a situation in which you have absolutely no control or choice.

- If you are in a car accident, that is an emergency.
- If you are in the emergency room or at urgent care, that is an emergency.
- If your car battery is dead when you try to start your car, that is an emergency.
- If someone in your immediate family dies, that is an emergency.

We, at **Crosspointe Family Services**, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling **208-736-7090**.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or text to you is made/attempted one (1) business day prior to your scheduled appointment. Please plan to arrive for your appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. If necessary, please cancel or change your appointment with at least a 24 hours' notice; there is a waiting list to see the clinicians at **Crosspointe Family Services** and, whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than 24 hours is given to cancel or change an appointment, this will be documented as a "No Call/No Show" appointment.

3. If you do not show up to the office for your appointment, this will be a "No Call/No Show" appointment.

4. After the first "No Call/No Show" appointment, you will receive a phone call or letter warning that you have broken our "No Call/No Show" policy. **Crosspointe Family Services** will assist you to reschedule this appointment, if needed.

5. After the 2nd "No Call/No Show" appointment, you will be removed from your counselor's schedule and will only be able to make a return appointment with that counselor's approval. You will not be able to make an appointment with any other clinician in our office.

I have read and understand Crosspointe Family Services' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify **Crosspointe Family Services** appropriately if I have difficulty keeping my scheduled appointments.

______________________________ ____________ ____________

Patient Name | Date of Birth | Date

______________________________ ____________________

Patient Signature or Parent/Guardian if minor | Relationship to Patient

______________________________ ____________________

Staff Signature | Date

Form K 3 2019

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1995

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ____ + ____ + ____

=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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 ________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Telehealth Informed Consent Form

I ____, consent to engaging in telehealth with Crosspointe Family Services as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications. I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Crosspointe Family Services that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth based services and care may not be as complete and in-person services. I understand that if my therapist believes I would be bettered served by other interventions I will be referred to e mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of doxy.me, healthsafeid.com, and simplyclinical.com systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Crosspointe Family Services or its staff liable for gathering or use of client information by these service providers.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

____

Signature of client/parent/guardian   Date

____

Printed name of client/parent/guardian   Relationship (If applicable)

____

E-mail (for visit links)