DEMOGRAPHIC FORM DATE:_____ /_____ /_____

If minor, Guardian name:____

PATIENT NAME: ____

DOB: ____________AGE: _______ SSN: ______-____-______

MALE ☐FEMALE☐ OTHER ☐

ADDRESS: ______________________________ CITY: ______________ STATE: __________ ZIP: __________

RACE: ________________ ETHNICITY: ________________ PREFERRED LANGUAGE: ________________

PHONE: (____) ____________ ALTERNATIVE PHONE #: (____) ____________EMAIL: ________________

May we leave you messages on your answering system regarding appointment reminders and/or services that may interest you? ☐YES☐NO

MARTIAL STATUS: SINGLE☐ MARRIED☐ SEPERATED/DIVORCE ☐ WIDOWED ☐

EMERGENCY CONTACT NAME: ________________RELATIONSHIP: ____________PHONE #: (____) ____________
REFERAL SOURCE: ______________________PRIMARY CARE PHYSICIAN: ______________________
PREFERRED PHARMACY: ______________________PHARMACY PHONE: ______________________

Legal Authorized Representative (LAR) is a person authorized by law to act on behalf of an individual who includes, parent, guardian, or manager conservator.

DO YOU HAVE AN ASSIGNED LEGAL AUTHORIZED REPRESENTATIVE (LAR)? YES ☐NO ☐

NAME:______________________________PHONE ______________________

ADDRESS: ______________________________ CITY: ____________ STATE: __________ ZIP: ________

PRIMARY INSURANCE:

INSURANCE NAME: ______________________ NAME OF INSURED: ______________________
RELATIONSHIP: ______________________ DOB: ________________ SSN: ______-____-______
MEMBER ID:______________________________GROUP ID (IF APPLICABLE) ________________

AUTHORIZATION NUMBER: ____

SECONDARY INSURANCE:

INSURANCE NAME: ______________________ NAME OF INSURED: ______________________
RELATIONSHIP: ______________________ DOB: ________________ SSN: ______-____-______
MEMBER ID:______________________________GROUP ID (IF APPLICABLE) ________________

COPY OF INSURANCE CARD NEEDED

MEDICAL HISTORY **Date:______/______/______**

Patient Name: ____

DOB: _______/_______/______

1. **Medical History: ____**
2. **Has patient had any surgeries? What type and dates:**

   ____
3. **Has patient had any psychiatric hospitalizations and if so please list dates and name or names of hospital**

   ____
4. **Does patient smoke/vape/dip? How many times a day____________________________**
5. **Does patient have allergies to any medications or food? ___________________________**

   ____
6. **Does patient drink alcohol? If yes, how many drinks per day? ________________________**
7. **Does patient have a history substance abuse? __________________________________**
8. **Has patient had any accidents or injuries that we should be aware of?**

   ____
9. **List any current medications: ____**

   ____

Patient /Guardian signature: ________________________ Date:______/______/______

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.

Authorization for Disclosure, Use, or
Receipt of Protected Health Information

You have the right to refuse to sign this authorization. La Mente Behavioral Health will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

Individual: ______________________ DOB: ______________ SS#: ______________

Dates of Service:

I authorize the designated staff at La Mente Behavioral Health ~~(Name of facility)~~

to disclose/use/receive the following protected health information* about me:

___ Psychiatric Evaluation ___ Laboratory Reports ___ Treatment Plans ___ Psychotherapy Notes
___ Physical Exam ___ Referral Instructions ___ Physician's Progress Notes ___ Social Service Notes
___ Discharge Summary ___ Physician's Orders ___ Nursing Notes ___ Other (specify) ___________
___ Copy ENTIRE record ___ Discharge Instructions ___ Med Reconciliation ___________

The facility's designated staff may disclose to/receive from: ______________________

(Name of person, organization, or facility)

Address: ______________________

____

Phone: ______________ Fax #: ______________

The disclosure is for the following purpose(s):

______ To coordinate my discharge planning/placement ______ To assist in my educational placement
______ At my request ______ To assist in additional funding
______ To discuss with my family the care and treatment I receive
______ Other (Specify) ______________________

*By signature below, I hereby authorize La Mente Behavioral Health to Release and to Obtain information with respect to any physical, psychiatric or drug/alcohol related condition, including treatment of Acquired Immune Deficiency Syndrome (AIDS) and/or HIV testing obtained during the course of diagnosis and/or treatment to/from the individuals(s) or healthcare provider(s) indicated below. The type of information authorized for disclosure includes, but may be limited to, that which is indicated below.

Note: If you are authorizing disclosure of information, then, except for information related to alcohol or drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then it is no longer protected by medical privacy laws.

Note: If you are signing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. Te revoke this authorization, you must deliver a written statement, signed by you, to the organization of facility where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

Unless this authorization is revoked earlier, it will expire one hundred eighty (180) days from date of signature.

______________________________ ______________

Parent's Signature/ Patient Signature Date

______________________ ______________________ ______________

Representative's Signature, if any Representative's relationship to individual Date

As of the date specified I wish to Revoke this authorization ______________________ Individual's Signature ______________ Date

A photocopy or facsimile transmission is as valid as the original

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

It is required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical and mental health records and other identifiable health information. The HIPPA privacy regulations require, or health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, shared. This applies to all forms of PHI, including paper, oral and electronic, etc. Furthermore, only the minimum health information necessary to conduct business is to be used or shared. The explanation of how **La Mente Behavioral Health LLC** handles your (PHI) is found on the Notice of the Privacy Practices (NPP). Please acknowledge below your receipt and understanding of the NPP:

You have the right to revoke this consent in writing signed by you at any time. Full disclosure will then cease: however, such revocation is not retroactive.

(Please initial below)

_____I acknowledge that I have read and understand the Notice of Privacy Practices, which explain how my protected health information is used and disclosed.

_____I acknowledge that I can receive a copy of the Notice of Privacy Practices at any time upon request.

_____I acknowledge that I can access my medical record upon request, with exception to psychotherapy notes, which are separated from medical records.

_____I acknowledge that I can change my mind on how I want **La Mente Behavioral** Health LLC to use or share my information other than as described here. If I change my mind, I will let La Mente know in writing.

_____I acknowledge that La Mente Behavioral Health cannot disclose my health information other than what was specified in the notice.

_____I acknowledge that La Mente Behavioral Health reserves the right to change the terms of the notice at any time.

By signing this form, you consent to our use and disclosure of you protected health information (PHI) and potentially anonymous usage I publication. You understand that PHI may be used and disclose for treatment, payment and health care operations. **LMBH** reserves the right to change the privacy policy as allowed by law.

Print Patient Name: ________________________________ Date:_____/______/_____

Parent/LAR signature: ________________________________ Staff/Witness:______________________________

CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommend medial or diagnostic procedure to be used, so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At his point of your care, no specific treatment plan has been recommended. This consent for is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and /or medication for any identified conditions.

Patient Name: ____ Date: _____/ _______/_______

The consent will remain in full effect until it is revoked in writing. You have the right to revoke this consent and discontinue services at any time. You have the right to discuss the treatment plan with your physician or provider, regarding the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your physician or provider, we encourage you to ask questions.

This consent provides La Mente Behavioral Health with your permission to perform reasonable and necessary medical examinations, mental health assessments, testing and treatment. By signing below, you are indication that:

(1) You intend that this consent is continuing in nature, even after a specific diagnosis has been made and treatment is recommended.

(2) You consent to treatment at this office or any other satellite office under common ownership.

(Please Initial)

______I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist), other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

_____I understand that if additional testing, invasive or interventional procedures are recommended. I will be asked to read and sign additional consent forms prior to the test or procedures recommended.

_____I certify that I Have read and fully understand the above statements and consent is fully and voluntarily to its contents.

Patient /LAR signature: ____ Date: ________/_______/_______

Printed name of LAR: ____ Relationship__________________

Staff/witness: ____Date: _______/________/_______

PATIENT AGREEMENT FORM

Thank you for selecting La Mente Behavioral Health. In order to facilitate your treatment, we ask that you read and sign this agreement and authorization.

- Should you need to cancel your appointment, we request a 24 hr notice.
- You agree to be responsible for payment of all fees in full at the time of your appointment, including co-payments.

FINANCIAL AGREEMENT

Your insurance company requires a Co-payment/ Coinsurance to be paid when you seek certain medical services. In turn, we are contractually obligated to collect any deductible, co-payment, or coinsurance from our patients.

I acknowledge that my insurance company and I have an agreement and I am responsible for the payment of any co-payment, coinsurance, or deductible for services provided to me, or my dependent.
I promise and attest that I will pay the required deductible, co-payment, or coinsurance to La Mente Behavioral Health within thirty (30) business days from receiving a bill. Patient statements are mailed when explanation of benefits are received from your insurance company.

______________________________ _______________

Signature of Patient Date

CONSUMER RIGHTS

Dear Consumer,

This is to inform you of your rights and how to access your records with La Mente Behavioral Health. This notice contains a patient's rights section describing your rights under the law. You are ascertaining by your signature, that you reviewed our notice before signing this consent.

- You have a right to file a complaint (brochure of client rights available at front desk)
- You have a right to Individual Responsibilities.
- You have a right to your case records, upon request
- You have a right to be notified and informed when changes are made to the program
- You have a right to be treated with dignity and respect
- You and your family have a right to be provided with information/education in the language of your choice.
- You have a right to appoint a relative or surrogate when you are incapacitated to request an advance directive.
- You have a right to designate a relative or surrogate to deliver and execute your established advance directive. We will comply.
- You have the right to restrict how we disclose your protected health information. We are not required to agree with this restriction, but we will honor it.

I understand that I can request a review of services if I am dissatisfied, have any concerns or found ineligible for services.

The process to do this has been explained to me as follows:

1. To request a review of my concerns or the decision to modify services, I can contact the Clients Rights Advocate of any other La Mente Staff verbally, or in writing.
2. I can grant consent to which I choose to be with me during a review or inquire about changes.
3. I will have the opportunity to express my concerns in person, in writing, by phone or have a representative speak with e the reviewers on my behalf.

Natasha Rivera, Client Right advocate
811 Chelsea Street, Ste B
El Paso, Texas 79903

Department of Aging and Disability Services
(DADS) Consumer Rights & Services
1-800-458-9858

For Abuse, Neglect or Exploitation
Contact: Department of Family and Protective

Disability Rights Texas
1-800-948-1824 (MHID)

Consumer/ LAR signature:____________________________Date:______/______/_______