Welcome to U Are Well

(completed by patient or parent/legal *guardian)*

Patient Name____ File#:___________________

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals are essential for the best benefit of therapy. If you ever have any questions about the nature of the treatment or anything else about the care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and therapist is held strictly confidential, and the therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws,
2. The patient presents an imminent danger to self,
3. The patient presents an imminent danger to others,
4. Child/elder abuse/neglect is suspected,
5. As necessary for continuity of care,
6. If a judge determines that our discussions are not confidential. a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3 and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. U Are Well follows the 'minimum necessary" rule for release.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and other cc-treating health care providers and facilities for the purposes of treatment, payment and Health Care Operations. I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out psychological examinations, treatment, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

GENERAL CONSENT FOR TREATMENT (If patient is a child or dependent of beneficiary)

On the patient's behalf, I (the legal Guardian or Legal Representative) authorize U Are Well to deliver mental health services to the patient. I understand that all policies stated on this page apply to the patient. I accept **that the child's records** are confidential and **that by law,** I cannot have access **to the child's records if such access would be detrimental to the child.**

CONSENT TO TREATMENT SIGNATURE

_______________________________ ____________ ____________________________________

Patient/Legal Representative Signature Date Provider Signature and License Date

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION WITHIN U ARE WEll

I authorize that U Are Well providers may disclose anv information, including Drug and Alcohol Abuse and HIV status, regarding my (my child's) treatment for purposes of Continuity of Care. I know I have the right to revoke this Authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without Continuity of Care, and may elect to transfer my care outside of U Are Well. This Authorization is valid as long as I am treated at U Are Well, or by my revoking this Authorization in writing.

_______________________________ ____________

Patient/Legal Representative Signature Date

Welcome to U Are Well

Patient Name ____ File#:____________________

FINANCIAL TERMS

I understand that U Are Well (Susan Graf -Cote) is performin a courtesy for me bv billing mv insurance company and it is ultimately mv responsibility to know mv insurance benefits and coverage. Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my provider will be paid directly by the carrier. U Are Well will make every effort to assist me in getting my claims paid correctly. However, U Are Well may need to contact *me* to have me help resolve claim issues with my insurance company. I will be responsible for any applicable deductibles and co-payments at the time ofservice. I agree to make these payments at each appointment. I understand that I will incur a charge of $10 for any balance not paid and for every time U Are Well generates a bill for me. I do have the option of paying cash, due at time of service, and then billing my insurance company directly for reimbursement. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. I understand the charge for a bounced check is $20.

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) are denied certification (Appeal). I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to the Provider, Clinical Director, or Quality Management Team at any time to register a complaint about any aspect of my care. When appropriate, individual cases will be reviewed by Susan Graf-Cote. If I am not satisfied with the response I receive, I may submit the Grievance to my insurance directly.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the phone service and your call will be returned. If an emergency situation arises, follow the emergency procedures and/or inform the answering service that your call is an emergency. Please do this for true emergencies only. There may be a charge for telephone consultations that require 10 minutes orlonger.

SATISFACTION SURVEYS, ASSESSMENTS

To maintain and enhance the quality of the services I provide, you will occasionally be asked to provide me with your input regarding the care you receive. I value your opinions and assure you all information is kept confidential. When you are asked tc provide your thoughts during the course of your treatment, please provide me with your honest evaluation of the services you have received. I carefully consider all responses and make changes, when necessary, to provide enhanced services.

CANCELLED/MISSED APPOINTMENTS & REOUEST FOR RELEASE OF RECORDS

In the event of a "No Show" or failure to give a **full 24-hour** notice of a cancellation, a **$50** charge will be assessed to all late **cancellations and missed appointments.** If I sign to request my records to be released, there will be a $20 fee for release of records (government agency request are excluded).

____

Patient's Initials

I have received a copy **of the "Patients Privacy Notice" and Patient's/Client's "Rights and Responsibilities".**

____

Patient's Initials

____ ________________________

Patient/Legal Representative Name-Please *Print* Date

____

Patient/Legal Representative Signature

____ ________________________

Provider Signature and License # Date

U ARE WELL THERAPIST (MFT) PAPERWORK

INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name:______________________________ Patient File #:______________

DOB: ______________ Sex: _______ Marital Status: ______ Primary Care Physician: ______________

Occupation:____________________ Education:_________ Others living in the home: ______________

Emergency Contact:______________________________ Phoned: ______________________

PRESENTING PROBLEMS:

Please describe the reasons for seeking counseling (include date/month the problem started):

HISTORY OF PRESENT ILLNESS

Completed bv Patient/Client

Please indicate how the following symptoms/problems/complaints are effecting you:(Leave blank if no effect)

1)Little 2)Some
3)Much 4)Significant

___Eating habits/Appetite: eating more; eating less; weight change______; binge; purge.
Sleep: Trouble falling asleep; "Trouble staying asleep; Trouble waking up; Average # hours sleep______

___Decreased energy/Fatigue
Sexual functioning
___Loss of interest in activities
Tearfulness
___Hopelessness/Helplessness
Decreased attention span
___Inattentive/Distractible
Memory: Long term; short term
___Difficulty planning ahead
Opposition
Anger outbursts
___Impulse control; difficulty controlling physical behavior or hyperactive
___Mood changes
Anxious/Nervous
___Worry/Fear
Stealing
___Lying
Truancy
___Fire setting

Start Time:______________ End Time:______________

CLINICAL PRESENTATION

TARGET SYMPTOMS	MEASURABLE GOALS*
1.	
2.	
3.	
4.	

*TF = Time Frame (<3 mo, <6 mo, <12 mo, Ongoing)

Patient/Legal Rep. Signature Provider Signature/Licensed Date

U ARE WELL THERAPIST (MFT) PAPERWORK

INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name:____Patient File #:____________________

HISTORY OF PRESENT ILLNESS continued

Completed by Patient/Client	**Comnleted bv Provider** Target Svmptoms	MEASURABLE GOALS
Police/Probation involvement		
Spending sprees	5.	
Rapid Heartbeat		
Phobia		
Sweating		
Trouble Breathing	6.	
Flashbacks of traumatic event		
Nightmares		
menacing thoughts	7	
Hearing Voices		

Substance Use

Completed by Patient/Client	**Completed bv Provider** Comments	Completed bv Provider Goals and Interventions
Coffee (#____cups/daily) Cigarettes (#_____per day) Alcohol (#_____drinks/weekly) Date last drank: ____________	Describe onset and duration; blackouts; withdrawal; attempts to stop; legal problems; DUI; work problems; relationship problems; hospitalizations, treatment.	Recommendations: Does the patient/client need further evaluation? YES NO Referral for CD Tx needed?: YES NO Relapse *prevention;* education.
Street drugs: Type:________________________ Amount:______________________ Frequency:____________________ Date last used:_________________		
Prescription Drugs: Type:________________________ Amount:______________________ Frequency:____________________ Date last used:_________________		
Describe impact of substance Abuse use on your life:__________		
Past treatment for substance use:		
Family history of substance use:		

*TF = Time Frame (<3 mo, <6 mo, <12 mo, Ongoing)

Patient/Legal Rep. Signature Provider Signature/Licensed Date

U ARE WELL THERAPIST (MFT) PAPERWORK

INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name:____Patient File #:____________________

Psychological History/Functioning

Completed by Patient/Clieiit

Rate how the problems/svmptoms/ complaints are impacting areas of FUNCTIONING:

1) Mlld 2) Moderate 3) Severe

- Marriage/Relationship
- Work/School
- Family
- Friendships
- Financial situation
- Physical health
- Social interests
- Leisure activities
- Clubs/Group memberships
- Legal
- Housing
- Attending to daily living activities (i.e. shower, grooming, self care, etc.)
- Spirituality
- Current stressors

Other ____________________________

CLINICAL PRESENTATION & LEVEL OF FUNCTIONING

____

____

____

____

____

____

TARGET SYMPTOMS	MEASURABLE COALS *
1.	
2.	
3.	
4.	

WHAT DO YOU SEE AS STRENGTHS:____

WHAT DO YOU SEE AS WEAKNESSES: ____

GOALS FOR TREATMENT: ____

GOALS AND EXPECTATIONS OF SIGNIFICANT **OTHERS:**________________________________

____

MOTIVATION FOR TRE.4T1I4ENT:____

WHAT CULTURAL EXPERIENCES DO YOU FEEL WOULD BE HELPFUL IN YOUR TREATMENT: ____

____

Patient/Legal Rep. Signature Provider Signature/Licensed Date

U ARE WELL THERAPIST (MFT) PAPERWORK

INITIAL EVALUATION AND DEVELOPMENT OF TREATMENT GOALS

Patient/Client Name:____Patient File 4:____________________

last Treatment History

Completed by Patient/Client	Completed bv Provider Comments
Psychiatric or psychological treatment of any kind before? YES NO If Yes, What type of cure was received? Inpatient Outpatient Both When was the treatment? __________________ Where was the treatment? _________________ _________________________ How long was the treatment?_______________ Name(s) of therapist ordoctor:______________ _________________________ Were medications prescribed at that time? YES NO Not applicable If Yes, what was prescribed (include dosages if _________________________ Family history of psychiatric treatment: _________________________ Family members currently in psychiatric treatment: _________________________	

Patient/Legal Representative Must Complete the following Medical History

MEDICAL HISTORY: ____

ALLERGIES: ____

Current Medications: (Dosage, frequency, and prescribing M.D.) ____________________________

____

HISTORY OF INFECTIOUS DISEASES: (i.e. Encephalitis, Lyme Disease, Meningitis) None Reported Q

____

DATE OF LAST PHYSICAL: ____

Are you currently taking any medication for PAIN MANAGEMENT? YES NG

It YES, what medication? ____

Prescribing Pain Medication M.D. ____

Over the Counter Medications, Herbal Medicines, Supplements:___________________________

____

FEMALE LIFE CYCLE HISTORY: Current # pregnancy?___________Are you planning for pregnancy? ___________

If YES, when?____________________When was your last menstrual period? ______________________

Are you currently using any form of birth control? If YES, what?____________________________

Other information the provider should know (i.e. family medical history): ______________________

____

____

Patient/Legal Rep. Signature Provider Signature/Licensed Date

U ARE WELL

Coordination of Care

With Primary Care Physician and Healthcare Providers

PATIENT SECTION TO COMPLETE

Patient Name:__________________________ Patient Birth Date:______________

Patient Address, City, State, Zip:______________________________

Name of Patient's Primary Care Physician (PCP):______________________

PCP's Address, City, State, Zip:______________________________

PCP Phone #:____________________ PCP Fax #:____________________

I AUTHORIZE the disclosure of confidential mental health information between my Mental Health Provider and my Primary Care Physician. I give permission to disclose diagnoses and treatment information about my child or me for the purposes of Continuity of Care. I understand and expressly authorize the release of information related to anv Substance Abuse or HIVstatus. This authorization is valid unlcss revokcd bv me in writing at any time.

Patient/Legal Guardian Signature: ***Date:***______________

**Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.

<OR>

I REFUSE to authorize the release/exchange of any behavioral health and medical information between my behavioral health provider and my primary care physician/healthcare provider to promote the continuity of my behavioral health care and my general medical care.

*Patient/Legal Guardian Signature:*______________________ *Dute:*______________

**Patient/l.egal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.

BEHAVIORAL HEALTH PRACTIONER SECTION

Dear ______________________

Initial Psychiatric Evaluation
Treatment Update

I saw your patient for an initial evaluation on ______________________

Current diagnoses are ______________ ______________

(For Psychiatrists) I have prescribed the following medication and dosages: ______________________

____

Outpatient care is appropriate at this time and the initial treatment will consist of the following:

Medication Management Individual Psychotherapy Family/Conjoint therapy CD IOP

Inpatient care/partial hospitalization is necessary and patient has been referred to______________

Other Clinical:______________________________

____

If you need additional information, please contact me at U Are Well. (858) 414-0411 ______________

Provider Signature:______________________ Date:______________

Printed Provider Name: License #: ______________

Updated 5/2016

U Are Well Child/Adolescent Development Form

(For patients under 18 years old)

Patient/Client Name:______________________________Patient File #:__________

Date:____________________DOB:____________________Current Grade:______________________________

Pregnancy and Birth: Full term: Yes No C-Section: Yes No

Complications or problems during pregnancy and/or birth: ____

____

Developmental Milestones: stages) sat-un _____ crawled_______walked ______ talked _____ toilet training ______

Describe delays or complications in any of the above areas: ______________________________________

____

Describe any illnesses and/or surgeries or other medical conditions: ______________________________________

____

Traumas: Yes . No If Yes, describe: ____

Day Care: Yes No If Yes, Where/When: ____

Comments:____

Preschool: Yes No If Yes, Where/When: ____

Comments: ____

1st-5th Grade: Where: ____ Grades:____________________________

Describe behavior: ____

Type of classes (i.e. special ed., GATE, etc.) ____

Comments:____

6"'-8'" Grade: Where:____Grades: ____________________________

Describe behavior: ____

Type of classes (i.e. special ed., GATE, etc.)____

Comments: ____

____

Provider Signature Provider Licensed Date

U Are Well Child/Adolescent Development Form

(For patients under 18 years old)

Patient/Client Name:______________________________ Patient File #:__________

9" Grade and up: Current Grade: ______________________________

Describe behavior:______________________________

Type of classes (i.e. special ed., GATE, etc.) ______________________________

Comments: ______________________________

Social Development: Clubs: ______________________________

: ______________________________

Hobbies:______________________________

Family Life: (i.e. Include age and dates: adopted. parents divorced, significant losses/deaths, blended family, moves, etc.):

____

____

____

Describe Family Relationships: ______________________________

____

Describe Peer Relationships: ______________________________

____

Describe Problems: ______________________________

____

____

Form completed by:______________________________ Relationship to child:______________________________

____

Provider Signature Provider License# Date

CONSUMER NOTICE OF RIGHTS AND RESPONSIBILITIES

DIGNITY AND RESPECT

You have the right to be treated with considerations, dignity, and respect-and the responsibility-to respect the rights, property, and enx ironment of all physicians and oilier health care professionals, employees and other patients.

- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture, or economic, educational or religious background.

KNOWLEDGE AND INFORMATION

You have the right to receive information about the organization's services and practitioner, clinical guidelines, and members' rights and responsibilities.

You have the right-and the responsibility-to know about and understand your health care and your coverage, including:

- Participating with your physician and other healthcare professionals in decision-making regarding your treatment planting. Having participated rind agreed to a treat:nent plan, you have a responsibility *tD* fO!low the treatment plan or advise your provider otherwise.
- The names and titles of all health care professionals involved in your treatment.
- Your clinical condition and health status.
- Any services and procedures involved in your recommended course of treatment.
- Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
- How your health plan operates-as stated in your Policy and/or Certificate.
- The medications prescribed for you-what they are for, how to take them properly and possible side effects.

ELIGIBLE EMPLOYEE ACCOUNTABILITY/AUTONOMY

As a partner in your own health care, you have the right to refuse treatment providing you accept responsibility and the consequences of such a decision-and the right to refuse to participate in any medical research projects.

You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals. You also have the responsibility to:

- Identify you and insurance coverage or changes in coverage when receiving behavioral hea!th services.
- Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
- Be on time for all appointments and to notify your provider's office as far in advance as possible if you need to cancel or reschedule anappointment.
- Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain pre-authorization of service from Managed Care Company, if applicable.
- Notify your behavioral health plan within 48 hours or as soon as possible-if you are hospitalized or receive emergency care.
- Pay all required co-payments and deductibles at the time you receive behavioral health care services.

FILING A COMPLAINT

Please fill out our complaint form, available in all offices, if you have a complaint. The complaint will be forwarded to the Quality Management Department for follow-up. You will be contacted with the resolution within 5 business days. You may also contact the customer service department of your health plan. If you are *not* satisfied with the plans' resolution, you may appeal the decision. The California Department of Corporations is responsible for regulating health care service plans. The department has a toll-free number (800) 400-0815; to receive complaints regarding health plans. Ifyou have a grievance against the health plan, you should contact the plan and use the plans grievance process. If you need the department’s help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the departments' toll-free number.

RIGHT TO LANGUAGE ASSISTANCE

Under California Law, an individual seeking mental health services who has limited English proficiency has the right to request language assistance and interpretation, which will be provided by' the health plan. Notify the office staff or provider and we will help you receive these services.