Community Health Partners℠
PHYSICIAN HOSPITAL ORGANIZATION

Client Intake – Demographic Information

Date: _____

Name: _____**Date of Birth**: _____

Address: _____ **Zip:** _____

Gender: Male_____ **Female**_____

Social Security:

_____

Please Circle Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Unknown, Decline to Specify

Please Circle Ethnicity: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White, Other Race, Decline to Specify

Phone Home: _____ **Work:** _____ **Cell:** _____

Best Method to contact to confirm appointment: Email or Phone

Safe Email: _____ **Safe Phone #:** _____

Employer: _____**Marital Status:** _____

Please Circle Title of Responsible Party: Mr, Mrs, Ms, Miss, Dr, Jr, Sr, I, II, III

Responsible Party Name:_____

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Gender: _____ DOB_____

Relationship to Patient:

_____

Social Security:

_____

Please Circle Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Unknown, Decline to Specify

Please Circle Ethnicity: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander, White, Other Race, Decline to Specify

Employer: _____

Insurance Carrier:_____

Subscriber: _____ **Subscriber ID#**_____

Group Name: _____ **Group #**_____

Please present your Insurance card so that we can have a copy on file.

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General Authorization For Treatment

As a person(s) served:

I do authorize the clinician(s) at Community Health Partners, Emotional Wellness Department to administer assessment and treatment specified below.

_____ Biopsychosocial assessment and treatment including individual therapy, trauma therapy, EMDR, group or family therapy.

_____ Other (please specify) _____

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period. I understand that claims will be processed on my behalf. I understand that unless this service(s) is fully covered by my insurance plan, fees for services and application to deductible may apply. I have read and had this information fully explained to me. I have had the opportunity to ask questions and receive answers about my treatment.

The Emotional Wellness Department of Community Health Partners, does on occasion and where appropriate provide disability letters, letters regarding your ability to work, or letters that would inform providers of your mental health history. You must discuss these needs with your therapist in advance. If a letter is required attesting the client's needs the therapist will need a minimum of 72 hours' notice for completion. Letters are only provided to clients who have been seen for 3 sessions or longer. The Emotional Wellness Department does not provide companion/emotional support animal letters.

Clients are discouraged from having the therapist subpoenaed. Though the client's attorney, who initiates the subpoena request is responsible for the court appearance and testimony fees, it does not mean that the therapist's testimony will be solely in in the client's favor. The therapist will only testify their professional opinion and to the facts of the case. Additional fees and costs may apply that are not covered by insurance for legal preparation, appearance and testimony.

_____ _____

Signature of Person Served/Parent/Guardian Date

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Rights of Person Served

You are in partnership with Community Health Partners when receiving services.

Your rights are as follows:

- To be treated with dignity, courtesy and respect
- To ask for, consent for and receive quality treatment and services
- To receive services regardless of your place of residence, sex, race, age, sexual preference, national origin, ancestry, immigration status, veteran status, disability, or religion
- To maintain your legal and civil rights unless in Baker Act status
- To participate in the development, understanding and maintenance of your treatment
- To have reasonable access to records

Your responsibilities are:

- To supply, whenever possible, accurate information about illnesses, hospitalizations, medications, and other pertinent matters related to your physical and emotional health
- To respect the rights of all others and be considerate of them, including their privacy and confidentiality
- To report physical or mental abuse
- To keep your scheduled appointments, keeping missed appointments to a minimum and contacting within 24 hours if you need to cancel or reschedule your appointment
- To fully participate in your treatment

Community Health Partners rights are:

- To refuse service provision after you continually disregard your treatment, including no-showing three (3) times
- To refuse service provision to those clients/cases/situations that cause a professional conflict or threat to the clinician, the agency or the mission and vision of the practice.
- To report all suspected, disclosed, witnessed and/or confirmed abuse of a child or vulnerable adult to the Department of Children and Families and other necessary agencies.
- To give notice of your involuntary admission to your emergency contact person

_____ _____

Signature of Person Served/Parent/Guardian Date

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PHONE/EMAIL CONTACT CONSENT AND AUTHORIZATION
For The Emotional Wellness Program

I, _____, with respect to any services provided or that are planned to be provided to myself as the patient or, as an authorized legal representative, for the below listed individual as the patient, fully consent to and authorize Naples Physician Hospital Organization dba Community Health Partners, ("Healthcare Provider") or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) and/or email in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items and/or appointment reminders).

Please mark only one:

_____ I am the Patient

_____ I am the Parent/Legal Guardian, for:_____
Patient Name for whom I am responsible for

I consent to be contacted via the following method(s):(PLEASE DO NOT PROVIDE WORK EMAILS OR WORK PHONE NUMBERS)

Text Message, to the following personal phone number: _____

Email Message to the following personal email address: _____

Voicemail Message to the following personal phone number: _____

The automated system will try to contact you, if you consented as follows: text first, email second and voicemail last. Once it is successful with one of the methods you consented to the other methods will not be executed.

If you do not consent to one of the above contact methods you understand you will not receive notification(s) of upcoming appointments and will be subject to the No Show/Late Cancellation Policy as listed below. If you do not consent to email notifications, you will not receive any administrative announcements (ie. notification of office closings or changes), from Healthcare Provider and any amounts not covered under the insurance (if applicable) will be your responsibility and billings will be sent to the mailing address on file for the above-mentioned patient.

No Show and Late Cancellation Policy Effective January 1, 2018

Each client is forgiven for one missed/no show appointment. If the client misses a subsequent appointment, or does not cancel an appointment within twelve (24) hours of their scheduled appointment time they will be charged a fee of $30 for each subsequent appointment missed. The individual client will receive a bill in the mail from Community Health Partners. Services cannot continue with our clinicians until the balance owed has been paid in full.

Printed Name of Responsible Party: _____

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Emotional Wellness

Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with the Emotional Wellness Department of Community Health Partners (CHP) 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 that my first initial visit with the assigned therapist must take place in person at one of their offices. I understand that telehealth services are only available to those persons that the therapist determines are appropriate for virtual services and is limited to those clients who are over the age of 16 at time of enrollment. I understand and consent to providing a safe, confidential, private/personal and working email and phone number to the Emotional Wellness Department in order to access telehealth services.

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 Emotional Wellness Department of Community Health Partners (CHP) 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 a mental health professional 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.

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4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Advanced MD Telehealth platform audio/video systems are not 100% secure and may have issues with Wi-Fi 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 Emotional Wellness Department of Community Health Partners (CHP) 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)

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Joint Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and Florida Statute 394, this Notice applies to all sites owned and/or leased by Community Health Partners (CHP) where protected health information is created and maintained.

Definition: Protected Health Information (PHI) refers to all the information created and maintained (whether oral, written, electronic, magnetic or recorded in any form) by CHP when a member receives treatment or services.

General Rule: In certain circumstances we may use and disclose your PHI without your written consent. Examples of disclosures include:

- **For Treatment-** CHP may disclose information to past and future providers within CHP and to your CHP team for the purpose of coordinating the service you receive. CHP may also provide information to contracted providers who provide services you receive during your treatment. CHP will share information with your current healthcare providers outside of CHP if you offer the name and address of these providers and sign a release of information.
- **For Payment-** CHP will use and disclose your PHI to send bills and collect payment from you, your insurance company, and other payers for the care, treatment, and other related services you receive. Your PHI may also be submitted to business associate collection agencies as needed to secure payment for your service.
- **For Health Care Operations-** PHI may be disclosed to Florida and Federal regulatory agencies and licensing authorities.

Your PHI may also be used or disclosed without your authorization or written consent as follows:

- When required by Federal law and Florida Statutes
- When a serious and imminent threat to the health and safety of a person or the public has been made
- When threats concerning the well-being of the President of the United States have been made
- When research and development for educational purposes is being conducted
- When a court order has been issued
- When there is abuse, neglect, exploitation, domestic violence or criminal activity
- To contact you with an appointment reminder or to communicate information about your appointment

Other uses and disclosures of your PHI, including psychotherapy notes, will occur only with your written authorization. You may revoke authorization in writing at any time. CHP will make reasonable efforts to use or disclose the minimum amount of PHI necessary to accomplish the intended purpose.

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Release of Information

Person Served: _____
Date of Birth: _____
SSN: _____

I hereby authorize the disclosure of information from Emotional Wellness Department at Community Health Partners to:

_____
Organization or Person to Receive Information

_____
Address

_____
City, State, Zip Code

_____
Telephone Number

Reason for Request: ____Continuity of Care_____ Other: _____

I authorize the disclosure of information dates of service: _____

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization and do not need to sign this form in order to receive treatment. I acknowledge that I give consent to this disclosure as described above. I understand that I have the right to revoke this authorization at any time in writing. I understand that revoking this authorization will not affect any actions already taken on it. I understand that I am entitled to receive a copy of this authorization upon request. Each disclosure requires an additional signed authorization. This consent will expire 180 days after the date of my signing. I hereby agree to hold Community Health Partners and its clinicians harmless for any liability that may result directly or indirectly from the disclosure released in accordance with this consent.

_____ _____
Signature of Person Served or Parent/Guardian Date

Community Health Partners℠
Physician Hospital Organization

EMOTIONAL WELLNESS
EFFECTIVE 10/14/2019

NO SHOW AND LATE CANCELLATION POLICY

Each client is forgiven for one missed/no show on an appointment. If the client misses a second appointment, or does not cancel an appointment within twenty-four (24) hours of their scheduled appointment they will be charged a fee of $30. The individual client will receive a bill in the mail from Community Health Partners. Services cannot continue to be provided until the balance owed has been paid in full. Please be aware that clients can leave a confidential voicemail on 239-659-7751 or a confidential email to ew@chealthpartners.com and this will be sufficient notification.

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Please complete the information below. Information provided on this form is protected as confidential information.

Name_____Date:_____

Treatment History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, couples or family therapy, etc.)?

☐ No ☐ Yes, previous therapist/ practitioner: _____

Are you currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐No

If yes, please list and provide dates:

_____

_____

_____

_____

General and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Fair Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? (Please circle one)

Poor Fair Satisfactory Good Very Good

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Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise?_____

What types of exercise do you participate in?_____

Please list any difficulties you experience with your appetite or eating problems:_____

_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐Yes

If yes for approximately how long?.....

Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this?_____

Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe: _____

Do you drink alcohol more than once a week? ☐ No ☐ Yes

How often do you engage in recreational drug use?

☐ Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

What significant life changes or stressful events have you experienced recently?_____

What would you like to accomplish out of your time in therapy?_____

_____

_____

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Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family members relationship to you in the space provided (e.g. father, grand mother, uncle, etc.)

	Please circle	List Family Member
Alcohol/Substance Abuse	Yes/ No	
Anxiety	Yes/ No	
Bipolar Disorder	Yes/ No	
Depression	Yes/ No	
Domestic Violence	Yes/ No	
Eating Disorders	Yes/ No	
Obesity	Yes/ No	
Obsessive Compulsive Behavior	Yes/ No	
Schizophrenia	Yes/ No	
Suicide Attempts	Yes/ No	

Additional Information

Are you currently employed? ☐**No** ☐**Yes**

If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work?_____

_____

_____

Do you consider yourself to be spiritual or religious? ☐ **No** ☐ **Yes**

If yes, describe your faith or belief: _____

_____

What do you consider to be some of your strengths? _____

_____

_____

_____

What do you consider to be some of your weaknesses? _____

_____