THE FAMILY CONNECTION™
CHANGING MENTAL HEALTH

Participant Information

Name _____Treatment Start Date _____

Address _____ City _____ State ____ Zip _____

Home/Cell Phone _____ Work Phone _____

Birth date _____Age_____ SSN _____ Marital Status _____

Primary Insurance Provider _____ Insurance ID # _____

Primary Insured Name _____ Primary Insured DOB _____

Primary Insured SSN _____

Secondary Insurance Provider _____ Secondary Insurance ID # _____

Secondary Insured Name _____ Secondary Insured DOB _____ Secondary Insured SSN _____

Are you presently under a physician's care? YES NO

If yes, for what? _____

Physician's name _____Psychiatrist's name_____

Were you referred to this agency? YES NO

If yes, by whom_____

Do you have a Psychiatric Advance Directive (PAD)? YES NO

If yes would you be willing to provide us a copy for your record? YES NO

If No, would you like us to provide you information on a PAD? YES NO

Medication (s) and dosage (current) _____

_____

Have you received prior counseling? YES NO

If yes, was it: OUTPATIENT INPATIENT

When _____ Where _____

By whom _____ Length of treatment _____

Problem(s) treated _____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the same ☐ Somewhat Worse ☐ Much Worse

Form Completed By: _____

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Emergency Contact:
Name _____ Relationship _____
Address_____
Home/Cell Phone _____ Work Phone _____

Please see back

Please check any of reasons listed below which resulted in you seeking service.

- ❍ Depression
- ❍ Anxiety
- ❍ Issues w/partner
- ❍ Communication Difficulties
- ❍ Alcohol or substance use
- ❍ Difficulty with loss or death
- ❍ Problems at school/work
- ❍ Issues w/Family

- ❍ Relationship enhancement
- ❍ Parent/Child conflict
- ❍ Identity Issues
- ❍ Court-ordered for: _____
- ❍ Gambling
- ❍ Personal Growth
- ❍ Medical: _____
- ❍ Trauma/Abuse
- ❍ Child Behavior/Acting Out
- ❍ Divorce
- ❍ Legal problems
- ❍ Parenting
- ❍ Skills Acquisition
- ❍ Other: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your over-all level of concern at this point in time (note: a problem may occur rarely but be of serious concern, or occur frequently, but be of little concern)?

Concern	**Frequency**
❍ No concern	❍ No occurrence
❍ Little concern	❍ Occurs rarely
❍ Moderate concern	❍ Occurs sometimes
❍ Serious concern	❍ Occurs frequently
❍ Very serious concern	❍ Occurs nearly always

On a scale of 0 to 10, how **IMPORTANT** is it for you right now to change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 Extremely Confident

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

Patient Name _____ Patient DOB: _____

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 Extremely Confident

On a scale of 0 to 10, how **READY** are you to make this change?

Not confident at all 0___1___2___3___4___5___6___7___8___9___10 Extremely Confident

This form has been completed to the best of my abilities and I attest that the information contained herein in accurate.

X _____ _____

Client/Parent/Guardian Signature Date

Patient Name _____ Patient DOB: _____

Consent for Treatment- Minor

I, _____ and _____ hereby request
(Parent/Legal Guardian) (Parent/Legal Guardian)
that my child, _____, born on _____ be accepted for mental
(Patient Name)
health treatment as described to me.

1. I/We give my authorization and consent to have the child named above receive outpatient diagnostic and treatment services from The Family Connection, LLC.
2. I/We understand that I/We have a right to have the child's information kept confidential. This information will remain confidential unless certain criteria are met; written consent to disclose certain information, if the child is in imminent danger or an imminent danger to self or others, if the child discloses abuse (physical, sexual, etc. or neglect) that The Family Connection, LLC is required by law to report, or if a court requires specific information.
3. I/We have received and understand the child's Rights and Responsibilities as a Family Connection, LLC patient regarding treatment and agree to these rights and responsibilities.
4. I/We have been given the Notice of Privacy Practices of The Family Connection, LLC which describes how medical information about the minor child may be used and disclosed.
5. I/We have been given The Family Connection's Social Media policy which describes how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.
6. I/We acknowledge that it is the policy of The Family Connection LLC to obtain consent from both legal parents/guardians for services to a minor child under the age of 14. Should one legal guardian actively deny consent for treatment, services will generally not be provided unless extenuating circumstances have been presented and approved by the clinical management team where it has been clearly demonstrated that more harm would come from not receiving treatment or that the consent of the other legal guardian is not able to be obtained.
7. I/We acknowledge that The Family Connection LLC conducts on-going in-house training and that details of the child's case, without identification of the patient, may be discussed to improve treatment during clinical supervision.
8. I/We have been given information regarding the cost of services from The Family Connection, LLC. I understand that I/we may be responsible to pay a co-pay and that it is payable each time I receive treatment. I/We also acknowledge that I/we am/are responsible for any fees not covered by the insurance company for the child.
9. I/We understand that I/We may discontinue treatment of the child at any time.
10. I/We have been given information about the advantages and disadvantages of the treatment recommended, as well as other alternatives. As with any effort to create lasting change, counseling requires time, energy and commitment. Counseling can feel frustrating because we cannot control the pace of change. On the path toward healing, clients may experience an increase in painful feelings; this is a normal part of the process.
11. I/We understand that I may address any concerns or grievances with my child's therapist or any other representative of The Family Connection, LLC at any time. I understand that the best practice is to work

with the therapist and supervisor to resolve any complaints but understand that I may also contact the licensing board which regulates my child's therapist's professional practice.

12. I/We authorize the release of any medical, mental health, or other information to my health insurance carrier or the other person or company paying for my treatment. The release of such information should be limited to that necessary to process claims for payment. I/We have a right to examine and request a copy of any information disclosed to insurers or other payors under this paragraph.
13. I/We authorize payment of medical benefits to The Family Connection, LLC for treatment services.
14. I/We acknowledge that the therapeutic process is most effective when family members and the therapist make a commitment to the therapeutic process. I/We understand that I/we will be assessed the full session fee for all/any appointment cancelled without 24-hour notice.
    1. I understand that the role of the therapy is treatment and it is policy of The Family Connection, LLC not to testify or otherwise participate in any legal proceeding unless legally compelled to do so. I agree not to involve The Family Connection LLC in any legal disputes, especially a dispute concerning custody or custody arrangements (visitation, etc.). I acknowledge as the parent/legal guardian of the adolescent child that if The Family Connection, LLC or any of its staff is subpoenaed regarding my adolescent child's care that I, as the legal guardian, will be financially responsible for all costs associated as outlined on the Client Financial Agreement per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

The signatures below reflect that I/We agree to the terms set forth above.

_____ _____

Signature of Parent/Legal Guardian & Date Signature of Parent/Legal Guardian & Date

Patient Name _____ Patient DOB: _____

Client Financial Responsibility Agreement

The Family Connection, LLC is committed to providing high quality mental health outpatient counseling. In order to do so, we expect payment at the time of service. The Family Connection, LLC will file insurance claims as a courtesy to those clients who are eligible for reimbursement through their insurance. However, the patient and/or financial/legal guardian are responsible for all fees associated with the services provided. We participate in many healthcare plans and work to provide each patient with a clear understanding of the patient's financial responsibility for services provided. The patient should understand they are responsible for payments – these payments can be made by the patient directly, by the insurance company or by a combination of both. Below is a listing of the approximate fees that may be associated with your care:

USUAL & CUSTOMARY FEE SCHEDULE:

Initial Consultation $200.00	Family Psychotherapy with patient $175.00
Individual Therapy Session (16-37 minutes) $90.00	Family Psychotherapy without patient $170.00
Individual Therapy Session (38-52 minutes) $120.00	Group Psychotherapy (per visit) $55.00
Individual Therapy Session (53-60 minutes) $190.00	Psychotherapy for crisis, first 60 minutes $215.00
Evaluation of records (per/15 minutes) $60.00	Crisis code, each additional 30 minutes $115.00
Preparation for court (minimum of 2 hrs.) ..... $250.00/hr.	Report preparation (per/15 minutes) $50.00
Records request ..... $6.50 avg min, estimated upon receipt of written request, based on copying time, supplies & postage	Court testimony (first 2 hours) .....$500.00/hr.
	Court testimony (each additional hour).....$250.00/hr.

I acknowledge that I have read and understand my obligations regarding the various options for reimbursement of services received at The Family Connection, LLC by initialing below:

Patient Name _____ Patient DOB: _____

THE FAMILY CONNECTION™
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Cash Patient/Sliding Scale – I agree to pay the entire session fee (s) prior to services rendered. I agree to submit a complete, thorough and accurate reflection of my entire household income by submitting monthly paystubs etc., to determine financial eligibility for a discount on services. I understand that I am responsible for paying the entire session fee prior to services being rendered, in order to qualify for a sliding scale discount.

Insurance Policy Coverage/Centennial Care - I understand that I am financially responsible for any applicable deductible, co-insurance or co-pays associated with my policy. I understand that my insurance plan may have negotiated specific rates for services rendered and I would be responsible for the cost my specific insurance has identified, provided my insurance covers the service. Should services be denied, I understand that I am responsible for all fees associated with my account and my care. I understand that my plan may have certain restrictions with regard to yearly visit limits, services covered, etc. and understand that I am fully responsible for ensuring my insurance has the information they need to provide coverage for the claim.

Records Requests/Court Fees – I understand that I am responsible for all fees associated with records requests and/or court fees. I acknowledge that these fees will not be covered by my insurance policy.

FINANCIAL POLICY STATEMENT

1. I understand that I am responsible for paying the full amount of each therapy session. TFC accepts cash, Visa, MasterCard, Discover and Health Savings Account cards as well as payments by check and debit cards. Payments may also be made in person and over the phone.

2. I understand that I may make a payment myself, use insurance, or use a combination of these two methods to pay.

3. TFC reserves a time slot especially for the patient. I understand that The Family Connection, LLC requires 24 hours' notice of cancellation of a scheduled session. Failure to cancel within this period will result in a charge for the session up to the billable amount of $100/hour.

4. I understand that The Family Connection, LLC will file insurance claims as a **courtesy** to those clients who are eligible for reimbursement through their insurance. If my insurance plan includes a co-pay, I understand that I am responsible for paying the co-pay on the day of the session. If the co-pay amount changes, I understand that I am responsible for paying the new amount for all sessions covered by the change. If, at any time, my insurance company denies coverage, I understand that I am responsible for the full amount of the session(s) not covered by the insurance. I understand that if I have an insurance policy with an annual deductible, I may

Patient Name _____ Patient DOB: _____

be responsible for the full amount of the session(s) until that deductible is met and that payment will be due at the end of each session. I understand that if the insurance company sends payment for services directly to myself, that balance must be sent or dropped off at The Family Connection at either the Rio Rancho or Los Lunas Office locations within 72 business hours of receipt.

5. I understand that I am responsible for notifying The Family Connection, LLC immediately of any changes in my insurance, including canceling a policy and/or plan change. I also understand that I am responsible for paying all sessions according to those changes.

6. I understand that it is my responsibility to set up a payment plan as soon as possible, in the case there are financial difficulties interfering with my ability to pay. We will work with each client to create a suitable payment plan. The Family Connection expects that you adhere to the contract you establish and notify us if the payment contract would need to be renegotiated. We do utilize the services of a collection agency. I understand that The Family Connection, will refer any balances over 60 days, not in a payment contract, to our collection agency and any fees associated with the collection agency, will be my responsibility. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection's efforts. TFC reserves the right to require payment for services to be made at or before the time of service for outstanding balances over $500. I further understand that TFC may refuse to see patients whose outstanding balances are over $500, and who are not making regular payments on the balance.

7. I understand that The Family Connection believes that the issues you have brought to counseling are important. We ask that you participate in this counseling contract by keeping the appointments you schedule.

8. The parent/guardian is responsible for payment of services rendered to your dependents account. I understand that it is the policy of the Family Connection that in circumstances where the parents share legal custody that both parents shall be responsible for the payment of services provided their child. I agree to accept that responsibility for such payments.

Attestation Statement:

I have read, understand, and agree to comply with The Family Connection, LLC Client Financial Responsibility Policy outlined above. I understand that I am responsible for all charges associated with my care, including but not limited to charges not covered by my insurance company, as well

Patient Name _____ Patient DOB: _____

as applicable co-payments and deductibles. I acknowledge that these policies do not obligate The Family Connection, LLC to extend credit.

I authorize my insurance benefits to be paid directly to The Family Connections, LLC.

I authorize The Family Connection, LLC to release pertinent information to my insurance company when requested or to facilitate the payment of a claim.

_____

Patient / Responsible Party Print Date

_____

Patient / Responsible Party Signature Date

Patient Name _____ Patient DOB: _____

THE FAMILY CONNECTION
Changing Mental Health

Patient Name _____ **DOB** _____

Clients' Rights and Responsibilities

- You have a **right** to receive information about The Family Connection, LLC services, therapists, treatment guidelines and your rights and responsibilities.
- You have a **right** to be treated with dignity and respect.
- You have a **right** to privacy and confidentiality. I understand that during couple's session's confidentiality goes to the couple unit.
- You have a **right** to participate with your therapist in making decisions about your treatment planning.
- You have a **right** to access supports outside of your counseling appointments, such as the use of 911 in emergencies or the 24/7 NM Crisis & Access Line at 1-855-662-7474, a free and confidential support service
- You have a **right** to voice complaints about The Family Connection and/or the care provided to you.
- You have a **right** to make recommendations regarding these "Clients' Rights and Responsibilities".
- You have a **responsibility** to provide, to the extent possible, information that The Family Connection, LLC and its therapists need in order to care for you.
- You have a **responsibility** to follow the plans and instructions that you have agreed upon with your therapist.
- You have a **responsibility** to participate, as much as possible, in understanding your behavioral health problems and developing mutually agreed-upon treatment goals.
- You have a **responsibility** to cancel your appointments with a minimum of 24-hour notice.
- You have a **responsibility** to notify and work with your therapist regarding any concerns of safety to yourself or others, including following through on agreed upon safety contracts.

Signature_____ Date_____

Signature_____ Date_____

Behavioral Health Release of Medical Information for Care Coordination with PCP

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name (if applicable): _____ Relationship to patient: _____

The current health care system is complicated. When patients get care, they may interact with any number of providers across multiple settings and if health care providers don't coordinate with each other, the consequences can be harmful to the patient. As a community provider we aspire to ensure that you get the best quality care, which includes providing you the opportunity to allow your care to be coordinated with your primary care provider. Please complete the form below to advise us what information, if any, you would like shared with your primary care provider.

❑ **I DO NOT authorize** information about my physical/behavioral health treatment to be released

❑ **I authorize** The Family Connection, LLC to use and disclose the protected health information as indicated below:

- o All health records related to drug/alcohol/substance abuse
- o All health records related to emotional/mental/developmental disabilities/psychiatric conditions **(excludes psychotherapy notes)**
- o Other: _____

Release of medical information from/to The Family Connection LLC to/from my:

Primary Care Physician: _____
Address: _____
Phone: _____ Fax: _____

I understand that this medical information may be used to coordinate my care.
I understand that I may cancel this authorization, in writing, at any time. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation. I understand that this will remain in effect until the end of treatment unless a date of expiration is indicated here: _____

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative **Date**

THE FAMILY CONNECTION
Changing Mental Health

Behavioral Health Release of Medical Information for Care Coordination with PCP

Patient Name: _____ DOB: _____

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_____ _____

Signature of patient or personal representative **Date**

THE FAMILY CONNECTION
Changing Mental Health

Symptom Distress Scale

During the last seven (7) days, about how much were you distressed or bothered by:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
a. Nervousness or shakiness inside……	1	2	3	4	5
b. Being suddenly scared for no reason……	1	2	3	4	5
c. Feeling fearful……	1	2	3	4	5
d. Feeling tense or keyed up……	1	2	3	4	5
e. Spells of terror of panic……	1	2	3	4	5
f. Feeling so restless you couldn't sit still……	1	2	3	4	5
g. Heavy feeling in arms or legs……	1	2	3	4	5
h. Feeling afraid to go out of your home alone……	1	2	3	4	5
i. Feeling worthless……	1	2	3	4	5
j. Feeling lonely even when you are with people……	1	2	3	4	5
k. Feeling weak in parts of your body……	1	2	3	4	5
l. Feeling blue……	1	2	3	4	5
m. Feeling lonely……	1	2	3	4	5
n. Feeling no interest in things……	1	2	3	4	5
o. Feeling afraid in open spaces or on the street……	1	2	3	4	5
ADD ALL COLUMNS					
				TOTAL (min: 15, max:	

Client Name DOB SS# Date

Scored By Title Date Scored

For Office Use Only:

Scoring: Items rated 3 or higher are considered to indicate serious distress. A total summed score of 25 or above indicated moderate distress; Scores of 33 or above indicate severe distress that requires immediate intervention

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505-717-1155

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Name: DOB:

Adult Depression Screening Form

Zung Depression Self-Rating Scale ©

INSTRUCTIONS: Please fill in one response for each of the 20 statements below based upon how you have been feeling over the past two weeks or longer. Then, please respond to the free-standing statement after item 20.

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time	Item Rating
1. I feel downhearted, blue, and sad.	❍ 1	❍ 2	❍ 3	❍ 4	
2. Morning is when I feel best.	❍ 4	❍ 3	❍ 2	❍ 1	
3. I have crying spells or feel like it.	❍ 1	❍ 2	❍ 3	❍ 4	
4. I have trouble sleeping through the night.	❍ 1	❍ 2	❍ 3	❍ 4	
5. I eat as much as I used to.	❍ 4	❍ 3	❍ 2	❍ 1	
6. I enjoy looking at, talking to, and being with attractive women/men.	❍ 4	❍ 3	❍ 2	❍ 1	
7. I notice that I am losing weight.	❍ 1	❍ 2	❍ 3	❍ 4	
8. I have trouble with constipation.	❍ 1	❍ 2	❍ 3	❍ 4	
9. My heart beats faster than usual.	❍ 1	❍ 2	❍ 3	❍ 4	
10. I get tired for no reason.	❍ 1	❍ 2	❍ 3	❍ 4	
11. My mind is as clear as it used to be.	❍ 4	❍ 3	❍ 2	❍ 1	
12. I find it easy to do the things I used to do.	❍ 4	❍ 3	❍ 2	❍ 1	
13. I am restless and can't keep still.	❍ 1	❍ 2	❍ 3	❍ 4	
14. I feel hopeful about the future.	❍ 4	❍ 3	❍ 2	❍ 1	
15. I am more irritable than usual.	❍ 1	❍ 2	❍ 3	❍ 4	
16. I find it easy to make decisions.	❍ 4	❍ 3	❍ 2	❍ 1	
17. I feel that I am useful and needed.	❍ 4	❍ 3	❍ 2	❍ 1	
18. My life is pretty full.	❍ 4	❍ 3	❍ 2	❍ 1	
19. I feel that others would be better off if I were dead.	❍ 1	❍ 2	❍ 3	❍ 4	
20. I still enjoy the things I used to do.	❍ 4	❍ 3	❍ 2	❍ 1	
				RAW SCORE	
				SDS INDEX	

Patient Signature

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
I have recently thought of, or am currently thinking of, suicide.	❍	❍	❍	❍

THE FAMILY CONNECTION
Changing Mental Health

Electronic Communication Consent by Non-secure Transmission

Patient Name _____ **DOB** _____

CELL #: _____ **EMAIL:** _____

This consent form is for the communication of Protected Health Information ("PHI") that The Family Connection LLC may transmit, without the written authorization of the client, as described in the Uses and Disclosures section of The Family Connections Notice of Privacy Practices.

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with The Family Connection LLC there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communication with The Family Connection LLC.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____, hereby consent and authorize The Family Connection LLC to communicate my PHI through the following non-secure transmissions (please initial all of your choices):

_____ Cellular/Mobile Phone, including text messages

_____ Unsecured Email

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I, _____, consent and authorize The Family Connection LLC to transmit the following PHI by the above selected electronic communications (please initial all of your choices):

_____ Information related to scheduling/appointments
_____ Information related to billing & payments
_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____ My health record, in part or in whole, or summaries of material from my health record.
_____ Other information; Please describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent, in writing, at any time.

_____ _____
Signature of client, parent or guardian Date

* Please complete ***only*** if you ***DO NOT*** consent to the above non-secure communication means:
I, _____, ***DO NOT*** consent to the transmission of PHI via unsecure means but would rather receive information about communication through a secure portal.
_____ (Please initial)