ADULT INFORMATION

Today's Date:_____

Your Name:_____Preferred name to be used:_____

DOB:_____ Age:_____ Address:_____

Home Telephone No.:_____ Cell Telephone No.:_____

Work Telephone No.:_____ Email address:_____

On which telephone number listed above may we leave a private message for you, particularly about confirming appointments?

Home: ☐ Yes ☐ No **Cell**: ☐ Yes ☐ No **Work**: ☐ Yes ☐ No **Email address**: ☐ Yes ☐ No

May we text you confirmation information regarding your upcoming appointments: ☐ Yes ☐ No

How were you referred to The Wylie Center (please circle one): ☐ Friend or family member ☐ Insurance Company ☐ Physician ☐ Teacher ☐ Other:_____

Which of the following best describes your ethnicity (please circle just one)?

☐ African-American ☐ Asian-American ☐ Native American ☐ Pacific Islander
☐ Middle Eastern ☐ Hispanic (Mexican American) ☐ Hispanic (Caribbean/Cuban/Puerto Rican)
☐ Hispanic (South America) ☐ Hispanic (Central America)
☐ Hispanic(Spanish) ☐ White/Caucasian ☐ Multi-racial Other:_____

What is your current job (i.e., accountant, fell-time home-maker, part-time student, work at a coffee house, etc.)

_____

Which of the following best describes your annual before tax income level for the family in which you reside?

☐ $0 to $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $30,000
☐ $30,001 to $40,000 ☐ $40,001 to $50,000 ☐ $50, 001 to $60,000
☐ 60,001 to $75,000 ☐ $75,001 to $100,000 ☐ $100, 001 and above

Health Insurance Information

Name of Carrier:_____ Authorization No.:_____

Group or Subscriber ID:_____ Subscriber Name:_____

Subscriber's DOB:_____ Name of Subscriber's Employer:_____

Employer's Address:_____ Employer's Phone # :_____

Secondary Insurance Information:

Name of Insurance Provider:_____ Phone No.:_____

Insurance Identification No:_____ Group No.:_____

Name of the Subscriber:_____ DOB:_____

Name of Subscriber's Employer:_____

Family History

Which of the following best describes your current situation?

□ Single □ Married: □ Widowed: □ Separated legally

□ Living with someone romantically □ Roommate with no romantic attachment

Name of Spouse/Significant Other:_____Date of Birth:_____

Address:_____ Phone # :_____

Please list the names and dates of birth of all children and adults currently residing in the home with client:

1. Name:_____ DOB:_____ Age:_____
Relationship to Client:_____

2. Name:_____ DOB:_____ Age:_____
Relationship to Client:

3. Name:_____ DOB:_____ Age:_____
Relationship to Client:_____

4. Name:_____ DOB:_____ Age:_____
Relationship to Client:_____

EMERGENCY CONTACT PERSON NAME AND PHONE#:

_____

SPORTS OR OTHER ACTIVITIES

Please list any social activities in which you are enrolled (i.e., sports, learning a musical instrument, tutoring, Boy Scouts, Explorer Scouts, have a job, volunteering, etc.):

_____

_____

_____

EDUCATION

What was your highest level of education? _____

Name of the last school attended and field of study: _____

If you graduated, what degree did you obtain? _____

Were you ever identified in school as having a learning disorder? □ Yes □ No

If yes, please list what type of learning disorder - if you know it _____

HEALTH/MENTAL HEALTH

Name of PCP (Primary Care Physician): _____

Address: _____

Name of Psychiatrist _____

Address: _____

Phone No.: _____

Please list your current physical health conditions: _____

_____

Please list all of your allergies: _____

_____

Please list all of your medications, dosages and the reason for the prescription:

Name of Medication:	Dosage:	Reason:
Name of Medication:	Dosage:	Reason:
Name of Medication:	Dosage:	Reason:
Name of Medication:	Dosage:	Reason:

Have you ever been psychiatrically hospitalized? □ Yes □ No

If yes, name of the hospital: _____

Were you Suicidal: □ Yes □ No Homicidal: □ Yes □ No

Dates Services Received:_____Address of the facility: _____

Have you never been in mental health treatment before? □ Yes □ No

If yes, with whom? Name:_____

Telephone No.:_____ Dates Services Received: _____

Which of the following best describes how long you were in mental health treatment?

□ One session
□ Between 2 and 12 sessions
□ 6 mos. to one year
□ More than a year

Reason for ending treatment (tx):

□ Met tx goals □ Moved □ Didn't like the therapist
□ Didn't think it was working □ Family member wasn't supportive □ Other:_____

OTHER

Religious Affiliation (if any):_____

What brings you to therapy now?

What would you like to achieve from therapy?

What are your strengths?

What are your weaknesses?

Only If you are Involved with Child Protective Services, Parole, or Probation:

Name of Your Parole / Probation Officer:_____

Phone No:_____Address:_____

Please circle: Riv/ San Bernardino/ Orange/ San Diego/ Los Angeles or Other California County

Name of County Social Worker:_____

Phone No:_____Address:_____

Please circle: Riv/ San Bernardino/ Orange/ San Diego/ Los Angeles or Other California County

CONSENT TO TREATMENT

1 consent and agree voluntarily to receive psychological services from The Wylie Center These services include, but are not limited to, diagnostic assessments; crisis intervention; individual, group and/or family therapy; and consultations and referrals to other medical or behavioral health professionals. I understand that by consenting to treatment, personal health information may be exchanged in a limited way for treatment, payment, and healthcare operations purposes only.

I understand that I have the right to terminate treatment at any time. I also understand that I have the right to refuse to implement any recommendations, psychological interventions, or any treatment procedure.

I understand that 1am expected to benefit from treatment, but there is no implied or expressed guarantee that I will.

Initial here:_____

ORIENTATION TO MENTAL HEALTH TREATMENT

EXPLANATION OF TREATMENT

Welcome to the Wylie Center. Below is information about what to expect regarding mental health treatment.

Therapy occurs when an individual or family meets with a professional clinician to discuss their difficulties. The therapy session is a safe and private place to explore thoughts and feelings and look for ways to solve problems. While it is expected that you or your child will benefit from therapy, there is no guarantee. In fact, some people may feel worse before they get better. Therapy is a process which requires time, communication, and commitment from everyone involved.

Parents bringing their child to therapy will be asked to participate in the therapy sessions. Children under the age of 6, parents are expected to be in every session. Teenagers, on the other hand, parents may participate much less, though you must remain on site. If there is someone whom you wish to participate in therapy with you or your child, please discuss this matter directly and together you can determine when and if this is appropriate. Parents/ guardians/ county social worker need to accompany a child to therapy unless other arrangements have been made and agreed upon by the clinician. Children residing with caretakers other than their parents will be asked to bring documentation outlining the legal status of the caretaker. Foster children may only be seen in treatment when all of the intake paperwork is completed by the county social worker AND it is expected that the county social worker will come into at least one treatment session

Treatment is solution-focused, strength-based and requires a collaborative relationship with your clinician. She will give you an estimated length of treatment, and may require that you complete assignments between sessions. It is important that you comply with your treatment plan. Remember, we don't FIX you, but we helping you make the changes you want.

If your problems seem overwhelming right now, remember that your clinician will understand and take your hopes and fears into consideration. It is important that you comply with your treatment plan, be honest with your thoughts and feelings at all times, and provide all relevant information. You will not be judged or criticized.

Understand that the process of therapy may involve discussing unpleasant aspects of your life, during which you may experience sadness, guilt, anger, frustration and loneliness. Research shows that working through these feelings in therapy may lead to better relationships and improved functioning at home and work.

Initial here:_____

HIPAA
Our office complies with the Health Portability and Accountability Act of 1996 (HIPAA). Please review the Notice of Privacy Practices posted in our treatment office/ lobby. You may request a copy of this notice if you wish. I have been provided with an opportunity to review the **Notice of Privacy Practices**.

Initial here:_____

In-Home/ Community Treatment
In-home therapeutic services are provided for people referred through a specific contract with Riverside County Department of Mental Health for children ages 2 - 6 who meet specific treatment criteria. Our therapists are willing to provide in-home mental health treatment, but only for clients who are paying for this service in cash or who have private health insurance and are willing to pay for the additional travel expenditure time going to and from your home to provide this service. Our usual rates for therapy apply for all travel.

Initial here:_____ only if you are planning on receiving in-home treatment services.

Authorization to Release Info for Payment to my Insurance Company
I authorize the release of information to my health plan pertaining to claims, certification, case management, quality improvement, benefit administration and other related purposes. I consent to benefits being assigned to The Wylie Center for services rendered.

Initial here:_____

FINANCIAL POLICY
Please understand that we will bill your insurance; however you are responsible for co-payment amounts and deductibles as set by your benefit plan. If we are not a contracted provider with your carrier, you are responsible for full payment for services received. If you have a calendar year deductible, you are responsible for paying each visit in full until you have met the obligation with the insurance carrier. Co-payments are to be paid in full each visit. You are responsible for notifying the office before services are rendered if you have a change in coverage. If for whatever reason, your insurance coverage was not current at the time of services, you are responsible for 100% of the bill

Initial here:_____

CONF1DENTIALITY
Confidentiality is absolutely essential in mental health treatment. It is crucial that you feel free to discuss whatever you want in treatment without fear that information will leak out. No information revealed during our sessions will be disclosed to third parties without your explicit written permission. Please be aware though, that if you choose to utilize your insurance benefits, and thus we are filing insurance claims, obtaining treatment authorizations, and undergoing insurance audits, we must share the required details of your treatment with your insurance carrier.

There are *few exceptions to confidentiality where the law mandates disclosures even without your consent:*

1. If you report to your clinician any knowledge of child, elder or dependent abuse (sexual, emotional, physical, financial) or neglect, your clinician may be required by law to report it to the necessary authorities.
2. A dependent is defined as anyone age 18 or older who is unable to function independently.
3. Consensual sexual activity between a minor under age 14 and a minor age 14 and over is reportable by law. It is also reportable if there is a significant developmental difference between minors.
4. If you indicate that you intend to harm yourself or anyone else, your clinician must take responsible and precautionary measures to protect anyone in danger and report the matter to the necessary authorities.
5. In accordance with the Patriot Act, the federal government may access treatment information without

client consent or knowledge.

6. Any employee affiliated with The Wylie Center, or third party payor, may access your treatment record for the purpose of audits, consultation, supervision or billing.

7. If an agency, HMO, PPO, or another third party payor who has referred you for treatment, they may audit your treatment record.

8. We would like to better coordinate care with your primary care physician and we will encourage you to sign an Authorization to Release Information so that we may do so.

9. If you are under the age of 18, your parents or legal guardians have the right to be informed of your progress in treatment and may access your clinical record unless, in the opinion of the clinician, would have a detrimental effect on the minor's physical or psychological well-being.

10. A minor under 18 may consent to treatment without parental consent if any of the following criteria are met:

A. Client is the victim of incest;
B. Client is the victim of abuse;
C. Client has a current substance abuse problem;
D. Client is a danger to self/others; or
E. Lack of therapy would constitute a danger of serious mental health harm to self (personal or developmental crisis).

(If a minor consents to treatment him/herself, then the client's parent/ guardian will not be allowed to access records without written consent from the client).

Initial here:_____

GUIDELINES FOR DISCLOSURE OF PRIVILEGED INFORMATION

It is important to understand the ***difference between confidentiality and privileged communications. Confidentiality*** refers to the professional norm that information about clients not will be shared with third parties unless certain specific criteria are met. ***Privilege*** refers to the disclosure of confidential information in court or during other legal proceedings. For further information, please see California Evidence Code Section 1013. It is important for the client and/or the parent to know that the holder of privilege is the client, regardless of his or her age.

Initial here:_____

PRACTICE LIMITATIONS

We do not provide certain type of services: a) Forensic evaluations for legal purposes, b) Custody evaluations, c) psychiatric evaluations for medication prescriptions, d) Fitness for Duty evaluations, e) psychological testing, and f) do no serve as expert witness. Additionally, if we do not have an expertise in a specific diagnostic area, we will need to refer you back to your insurance company. In general, we do not have an expertise in treating eating, geriatric issues, and/or sexual offenders.

Initial here:_____

INFORMED CONSENT

1. I authorize treatment of myself and/or my dependents as indicated.

2. My signature below attests that I am the **legal** guardian of minors, being treated or I am the client being treated. I understand that my clinician may request court orders to show that l possess legal/physical custody of minors referred to The Wylie Center for treatment.

3. I understand that if my clinician requests authorization for additional sessions from my health insurance company, the necessity for further treatment and the effectiveness of treatment already provided will be assessed.

4. I authorize communication between my clinician and my healthcare practitioners for coordination of care.

5. If I am in individual treatment and I wish to bring in my partner or other family member into treatment, my clinician may or may not share information I have revealed in our individual sessions. My clinician will determine if it is clinically or legally indicated or if a conflict of interest exists so that appropriate referrals to another therapist are made.

6. No information regarding my treatment will be released to an outside agency (with the exception of information being shared with a child's county social worker when the child is a dependent of the court) without a written authorization to do so. The Wylie Center is not, however, responsible for maintaining confidentiality once information has left the office. I release the source of these records from any liability arising from their release.

7. I understand that I have the right to appeal decisions formally regarding my treatment by bringing up any issues with the CEO of The Wylie Center, or further, l may submit complaints to my health insurance company and to the California Department of Managed Health Care (toll free phone number 888-HM0-2219). I understand that I have the right to file a complaint with the U.S. Department of Health and Human Services (phone number 415-437-8310) if I feel that my health information has not been protected. I understand that I risk nothing in exercising these rights. If I am a MediCal client, I may also contact Riverside County Department of Mental Health's CARES program at (800) 706-7500 to discuss my concerns.

8. **If I am a foster child and/or a dependent of the court** I authorize my clinician to disclose to my county social worker general information regarding my participation in treatment lading, but not limited to: a copy of the Client Care Plans as well as a summary report indicating the number of sessions attended and/or missed, progress towards goals, what type of treatment has been provided (i.e., individual, family or group), participation of family members, potential for self-harm or any homicidal ideations, and any recommendations for future treatment or community services from which I might benefit.

Initial here:_____

CLIENTS' BILL OF RIGHTS

1. As a partner in your health care you have the right to refuse treatment at any time. If treatment is authorized, the client/member of the health plan accepts the consequences and responsibilities of such a decision.

2. Strict confidentiality or client information is observed. In order to ensure your confidentiality, **you are requested to not bring friends or extra family members to the clinic**. Please request a Release of Information form if you wish the clinic staff member to communicate with a friend, family or referring agency. You are advised that once you enter this clinic as a client, your rights are protected under State and Federal confidentiality rules and regulations. The exception to this may be a medical emergency, crimes or threats of criminal acts on the program premises, or against program personnel and other exceptions to the State and Federal Confidentiality rules and regulations.

3. It is the client's right to be treated with consideration, dignity, and respect from all staff, volunteers, and board members associated with The Wylie Center. A client will not be denied any right based on race, religion, sexual orientation, gender, ethnicity, disability or gender identification.

4. Clients are to be accorded safe, healthful and comfortable accommodations.

5. Clients are to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior while in treatment.

6. Clients have the right to access their own medical records, and to have the privacy and confidentiality of those records maintained as provided for in Title 42 of the Code of Federal Regulations, Part 2. All clients have access to their Treatment files in accordance with Executive Order #B-22/76.

7. All clients have the right to know their diagnosis and to jointly participate in the development and implementation of their treatment plan. Once having agreed with a treatment plan, the client and/or parent has a responsibility to follow the treatment plan, or to advise the clinician to the contrary.

8. All clients will be advised of the possible outcomes of treatment and their right to end or refuse treatment

and to inspect and obtain copies of your records per HIPAA regulations (see Notice of Privacy Practices Form). Copies are provided at a fee of .15 cents per page + fee for clinical time to make the copies.

9. A dual relationship (i.e., being friends with your therapist outside of treatment, doing any type of business with your therapist outside of treatment, etc.) with your clinician is strictly prohibited.

10. A client has the right to know about any services or procedures recommended during the course of treatment and any continuing care/follow-up required following discharge.

11. The client, or the person designated with the legal authority to make decisions regarding the client's health care, has the right to appeal or follow the grievance procedure of the health plan. The client has the right to examine and receive an explanation of the bill regardless of the source of payment.

Initial here:_____

CANCELLATIONS AND MISSED APPOINTMENTS

If you are going to miss an appointment due to illness or some other emergency, please call The Wylie Center as soon as possible prior to your scheduled appointment. **If you do not call prior to your scheduled appointment you will be charged for this session. If you miss two (2) scheduled appointments without calling to cancel the appointment. The Wylie Center will no longer be able to provide you with treatment services at this time**. Should treatment service be terminated after two missed appointments, no additional appointments will be made for a period of four months.

Initial here:_____

PROFESSIONAL FEES

Standard Services	**Cash/Check**	**Insurance**
Assessment, individual, family, or collateral mental health treatment	$95.00 per hour	Varies
Group Therapy	$25.00 per person per hour	

Miscellaneous fees which are generally not covered by insurance

Letter or report writing	$95.00 per hour
Phone calls	$ 5.00 per every 5 mins increments. For example, if you wish for me to consult with a child's pediatrician, teacher, or child care provider by phone)
Photocopying:	.15 cents per page in addition to an hourly rate of $25.00 per hour.
Court:	$500.00 minimum. $100.00 per hour for all preparation for court paid half in advance.

Initial here:_____

AVAILABILITY

Primarily The Wylie Center operates Monday through Friday. Evening appointments are available Monday - Thursday. At this point in time, we do not offer appointments on Saturdays or Sundays.

Initial here:_____

NON-DISCRIMINATION PRACTICES

The Wylie Center strictly abides by our policies ensuring that clients are not discriminated against in the delivery of mental health treatment based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, medical condition genetic information, claim, or source of payment.

Initial here:_____

EMERGENCIES
If you are having a life threatening emergency, please call **911 or go to the nearest emergency room**. If you call and the matter is urgent, you will receive a return phone call in less than 24 hours. If you call and state that it is non-urgent, your phone call will be returned within 72 hours.

Initial here:_____

_____
Client's Printed Name

_____ _____
Client's Signature Date

_____ _____
Your Mental Health Therapist Date

Adult Medical / Medication History

Client's Name:_____
DOB:_____ Age:_____ Date Completed Form:_____
Name of Current Physician:_____
Name of the Medical Group (if any):_____
Address of Physician:_____
Phone#:_____ Fax#:_____

Date of last physical:_____

Please list all of your allergies and substances to which you are ALLERGIC:

_____

_____

Please describe what happens when you have an ALLERGIC RESPONSE to something listed above:

_____

_____

Within the past year, which of the following PRESCRIBED MEDICATIONS have you taken?

☐ Asthma?	Name:	Currently using ☐ Yes ☐ No
☐ Sleep disturbance?	Name:	Currently using ☐ Yes ☐ No
☐ Nutrition?	Name:	Currently using ☐ Yes ☐ No
☐ Pain?	Name:	Currently using ☐ Yes ☐ No
☐ Pain?	Name:	Currently using ☐ Yes ☐ No
☐ Recreation/Relax?	Name:	Currently using ☐ Yes ☐ No
☐ Nerves/Anxiety Dep?	Name:	Currently using ☐ Yes ☐ No

Within the past year, which of the following OVER-THE-COUNTER or NATURAL HERBS have you taken?

1. If you have been **prescribed mental health type medications** in the past:

Names of Medication	# of years you used	What was it for?	Why stopped?

2. If you are **CURRENTLY** taking **mental health type medications**:

Names of Medication	# of years you used	What was it for?	Why stopped?

In order to provide the best mental health care, it is sometimes necessary to know some things about your physical condition. Please answer the questions as best you can.

1. When was the last time you had your **vision** checked?_____
2. Do you wear glasses or contact lens? ……□ Yes □ No
   a. If you answered yes to glasses, please describe your vision problems:
   _____
   _____

3. When was the last time you had your **hearing tested**? _____

4. Do you wear a hearing aid? ……□ Yes □ No
   a. If you answered yes to wearing a hearing aid, please describe your hearing problem:
   _____
   _____

5. When did you last have a physical examination? _____
6. Are you **currently under a physician's care** for something other than a regular, routine annual exam?
   □ Yes □ No
   a. If you answered yes, please describe the medical condition for which you are under a physician's care:
   _____
   _____

7. Have you ever had **surgery**? ……..□ Yes □ No
   a. If you answered yes, please describe the nature of yoursurgery:
   _____
   _____

8. Have you ever had a **head injury**, including sports injuries, falls, car accidents, etc.? …… ..□ Yes □ No
   a. If you answered yes, please describe how the head injury occurred and how it was treated:
   _____
   _____

9. Have you ever ingested something **poisonous**? .....□ Yes □ No
   a. If you answered yes, please describe what was ingested and how it was treated:
   _____
   _____

Please check all of the following with which you have been diagnosed at any time in the past:

□ Heart Problems	□ Drug Use	□ Liver Problems
□ Shortness of breath	□ Cancer	□ Immune System Problem
□ Unresolved Pain	□ Migraines	□ Frequent Headaches
□ High Blood Pressure	□ Head Injury	□ TB
□ Stomach Problems (GI)	□ Stroke	□ STD
□ Epilepsy/Seizures	□ Kidney Problems	□ Thyroid Problems
□ Asthma	□ Hay Fever/Hives	□ Dizziness/Fainting
□ PMS	□ Hormone Replace	□ Hepatitis
□ Unusual bleeding	□ Diabetes	□ Other:

PREGNANCY:

How many times have you been pregnant?_____

How many live births?_____

Are you taking birth control at this time? □ Yes □ No

If so, please describe:

ALCOHOL:

Have you ever drank alcohol? □ Yes □ No

Which of the following best describes your alcohol consumption in a typical month:

a) 0 drinks
b) 1 - 4 drinks
c) 4 - 8 drinks
d) 8-12 drinks
e) More than 12 drinks per month

Which of the following best describes you with regard to alcohol in the past:

a) Problem drinker
b) Alcoholic
c) Binge drinker
d) Other:_____

If you don't drink alcohol now, **but did in the past**, how long did you drink before you quit?_____

In what year did you quit?_____

TOBACCO:

Have you ever smoke / chewed / inhaled tobacco? □ Yes □ No

Do you go to Hooka bars? □ Yes □ No

Which of the following best describes the # of cigarettes you smoke or# of x you chew tobacco per week:

a) 0
b) 1 -1
c) 8 - 15
d) 15-21
e) More than 21 cigarettes per week

If you do not smoke tobacco now, but did smoke in the past, how long did you smoke before you quit?

_____

In what year did you quit?_____

SUBSTANCE ABUSE:

Please list all recreational substances you **use now or have used in the past**, # of years you used and why you stopped:

Name of Substance	# of years you used	Year you stopped	Why you stopped

10. Please list the name and relationship of **any relative who has received mental health treatment** of any kind as well as the name of the relative's mental health diagnosis, if known.

First Name of Relative	Diagnosis (if known)	What is your relationship to this person?

11. Please list the name and relationship of **any relative who has had a drug or alcohol problem** as well as the name of the preferred drug or alcohol and whether it is current or past abuse?

First Name of Relative	Type of Substance used (if known)	What is your relationship to this person?

Client's Name Printed **Date** **Signature of Client**

Therapist's Name Printed **Date** **Signature of Therapist**