

WELCOME

EXCLUSIVE PSYCHIATRIC CARE
 Selene Mendoza, CNP Dominique Pummil, CNP
 Dawn Goodheart, LPCC
 1161 Mall Drive, Suite C — Las Cruces, NM 88011

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____

_____ Name of Insurance Company(ies)

and assign directly to Dr. _____

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____

_____ Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ Signature of Beneficiary, Guardian or Personal Representative

_____ Please print name of Beneficiary, Guardian or Personal Representative

_____ Date _____ Relationship to Beneficiary

3 PHONE NUMBERS

Home (____) _____ Cell (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____

Work Phone (____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

Diabetes Cancer Bleeding tendency Kidney disease Tuberculosis

Heart disease Stroke High blood pressure Nervous illness Allergy Other _____

5

HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes/Halos

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sore that won't heal

MEN only

- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |

Describe serious illnesses or operations _____

6

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

7

HEALTH HABITS

Check (✓) which you use and how much:

- Caffeine _____
- Street Drugs _____
- Tobacco _____
- Other _____

Check (✓) if your work exposes you to:

- Stress
- Heavy Lifting
- Hazardous Substances
- Other _____

Your occupation _____

8

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date

**Consent to Treatment and Recipient's Rights
Exclusive Psychiatric Care**

Client _____ Chart # _____

I, _____ the undersigned, hereby attest that I entered into treatment, or give my consent for the minor person under my legal guardianship mentioned above.

Exclusive Psychiatric Care, hereby referred to as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Center non-voluntarily, if; A) the client exhibits physical violence, verbal abuse, carries weapons or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by Federal and/or State law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) The patient consents in writing, 2) The disclosure is allowed by a court order, or 3) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with Exclusive Psychiatric Care.

Signature of Client/Legal Guardian

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf.)

Date

Witness

Date

Privacy of Information Policies Exclusive Psychiatric Care

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Effective 4-14-03

Our Legal Duties

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by the ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exception in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intention or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety

Health records may be released for the public interest and safety for public health activities , judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g. diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes types of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is \$1.00 per page plus postage.

You have the right to cancel a release of information by providing us with written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information to us in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request the information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Department of Health and Human Services and/or the Exclusive Psychiatric Care. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: _____

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name: _____

Signature: _____ Date: _____

Signed by: Client Guardian Personal Representative

Recipient's Rights Notification Exclusive Psychiatric Care

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this brochure explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a Patient

1. **Complaints.** We will investigate your complaints.
2. **Suggestions.** You are invited to suggest changes in any aspect of the services we provide.
3. **Civil Rights.** Your civil rights are protected by federal and state laws.
4. **Cultural/spiritual/gender issues.** You may request services from someone with training or experiences from a specific cultural, spiritual or gender orientation. If these services are not available, we will help you in the referral process.
5. **Treatment.** You have the right to take part in formulating your treatment plan.
6. **Denial of Services.** You may refuse services offered to you and be informed of any potential consequences.
7. **Record Restrictions.** You may request restriction on the use of your protected health information; however, we are not required to agree with the request.
8. **Availability of records.** You have the right to obtain a copy and/or inspect your protected health information; however we may deny access to certain records in which we will discuss this decision with you.
9. **Amendment of records.** You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. **Medical/Legal advice.** You may discuss your treatment with your doctor or attorney.
11. **Disclosures.** You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. **Medication used in your treatment.** We will provide you with information describing any potential risks of medications prescribed at our facility.
2. **Costs of services.** We will inform you of how much you will pay.
3. **Termination of services.** You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
4. **Confidentiality.** You will be informed of the limits of confidentiality and how your protected health information will be used.
5. **Policy changes.**

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

Patient's responsibilities

1. You are responsible for your financial obligations to the clinic as outlined in the Payment Contract for services.
2. You are responsible for following the policies of the clinic
3. You are responsible to treat staff and fellow patients in a respectful, cordial manner, in which their rights are not violated.
4. You are responsible to provide accurate information about yourself.
5. You are responsible for a \$25.00 fee if you do not cancel your appointment 24 hours in advance prior to missing your scheduled appointment time.

What to do if you believe your rights have been violated.

If you believe that your patient rights have been violated contact our Recipient's Rights Advisor or Clinic Director.

Email Form