CONFIDENTIAL PATIENT HISTORY

THE MINDFUL HEALTH FOUNDATION

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health and/or substance abuse services. Please complete these forms as honestly and completely as possible. All of the information that you provide will be confidential as required by state and federal law.

Today's Date: _____ Social Security Number: _____

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City/State/Zip Code: _____

Home Phone: _____ Cell/Mobile Phone: _____

E-Mail Address: _____ May we contact you by phone and/or email? Yes No

Have you served in the military? Yes ___ No ___ If Yes, Branch and Dates of Service: _____

Referral Source: _____

What type of Discharge (separation) did you get? _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___

Remarried ___ Engaged ___ Widowed ___ Cohabitating ___

Sexual Orientation: (check one): Heterosexual___ Homosexual ___ Bisexual ___ I choose not to answer ___

Gender Identity: (check one): Birth Gender Female or unknown ____ Male ____ Female ____

Transgender Male ____ Transgender Female ____ Genderqueer (not male or female) ____

Additional Gender Category, please specify: _____ Choose not to disclose _____

If applicable, please complete the following:

Spouse/Partner's Name: _____ Spouse/Partner's Age: _____

Spouse/Partner's Occupation: _____

Do you have a Legal Guardian? Yes ___ No ____ If Yes, who? _____

Do you have children? ___Yes _____ No

If yes, please list their name, sex, and ages:

	Full Name of Child	Sex	Age	Do you have custody?	Is there an open/active DCF Case?
1.					
2.					

CONFIDENTIAL PATIENT HISTORY

Please list all adults and children who currently live in your residence?

	Name	Age	Sex	Relationship to you
1.				
2.				
3.				
4.				

In your own words, describe the current problems that you are having as you see them:

_____

_____

How long has this problem been going on?

_____

What made you decide to seek treatment now?

_____

What do you hope to gain from this evaluation and/or counseling? _____

_____

Are you referred by a Court or DUI Program? Yes ____ No ____

If Yes, please provide details: _____

_____

_____

Are you involved in a law- suit or expect to be involved in a law- suit? Yes ____ No ____

If Yes, please provide details: _____

_____

BEHAVIORAL HEALTH HISTORY:

Outpatient Behavioral Health History

Have you seen a counselor, psychologist, psychiatrist, or other mental health provider before in an outpatient setting?

Yes____ No____

If Yes, please fill out the information below:

Dates of Service	Name of Provider	Reason for Visit	Outcome or Level of Care

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Are you currently seeing a psychiatrist? Yes ____ No ____

If Yes, please provide the following information:

Name of Psychiatrist: _____

Telephone #: _____

How long have you been seeing this provider? _____

Inpatient/ Residential Behavioral Health History

Have you ever been hospitalized for psychiatric reasons? Yes ____ No ____

If Yes, please list below:

Date of service	Name of Facility/Hospital	Attending Physician or Psychiatrist	Outcome

MEDICAL HISTORY:

Medical Issues

Are you currently being treated for any medical issues? Yes ____ No ____

If Yes, please list below:

Condition/Diagnosis	Treating Physician

Medication

Are you currently taking any prescription medications? Yes ____ No ____

If Yes, please list below:

Name of Medication	Dosage	How long have you been taking it?	Prescribing Physician	Has it been helpful?

Have you been on psychiatric medication in the past? Yes ____ No____

If Yes, please list below:

Name of Medication	Dosage	How long were you on it?	Was it helpful?

Primary Care Physician

Primary Care Physician:_____

Phone #: _____ Fax #: _____

Date of last physical: _____ Date of last lab work: _____

Do you have any Allergies (Medication/ Food/ Seasonal) Yes ____ No _____?

If so, please list:

_____

_____

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Current Symptoms

Please check any symptoms or experiences that you have had in the last 30 days

Check	Physical	Check	Thoughts	Check	Feelings
	Difficulty falling asleep		Withdrawing from others		Anxiety
	Difficulty staying asleep		Difficulty getting out of bed		Depressed mood
	Sleeping too much		Difficulty leaving your home		Irritability
	Sleeping too little		Avoiding people, places, activities, or specific things		Frequent feelings of guilt
	Nightmares		Persistent, repetitive, intrusive thoughts, impulses, or images		Recent worry
	Eating too much		Feeling numb		Outbursts of anger
	Eating too little		Fear of certain objects or situations (flying, bugs, heights)		Rapid mood changes
	A sudden increase in energy		Unusual visual experiences such as flashes of light, shadows		Panic Attacks
	A decreased in energy		Feeling puzzled as to what is real and unreal		Sadness
	Loss of interest in activities you used to enjoy.		Repetitive behaviors or mental acts (counting, checking doors, washing hands)		Feeling or acting like a different person
	Difficulty concentrating or thinking		Feeling outside yourself, detached, observing what you are doing		Worthlessness
	Recent weight loss		Hearing voices when no one else is present		Fear
	Recent weight gain		Racing thoughts		Hopelessness
	Excessive exercising to avoid weight gain		Large gaps in memory		Helplessness
	Use of laxatives		Intrusive memories		Easily startled, jumpy
	Use of diet pills		Flashbacks		Inappropriate expression of anger
	Use of diuretics		Thoughts about harming or killing someone else		Ineffective communication
	Voluntary vomiting		Thoughts about harming or killing yourself		Difficulty expressing emotions
	Unusual sweating		Current abusive relationship		Difficulty meeting role expectations
	Tremors		Concerns about your sexuality or gender		Sense of lack of control
	An increase in muscle tension		Dependency on others or codependency issues		Difficulty or inability to say “no” to others
	Self-mutilation/cutting		Difficulty or inability to say “no” to others		Decreased ability to handle stress

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The Holmes-Rahe Scale

Read each of the events listed below and check the box next to any event which occurred in your life in the last two (2) years. There are no right or wrong answers. The purpose is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units		Life Events	Life Crisis Units	
Death of spouse	100		Son or daughter leaving home	29	
Divorce	73		Trouble with in-laws	29	
Marital separation	65		Outstanding personal achievement	28	
Gone to jail	63		Spouse begins or stops work	26	
Death of close family member	63		Begin or end school	26	
Personal injury or illness	53		Change in living conditions	25	
Marriage	50		Revision in personal habits	24	
Fired at work	47		Trouble with boss	23	
Marital reconciliation	45		Change in work hours or conditions	20	
Retirement	45		Change in residence	20	
Change in health of family member	44		Change in schools	20	
Pregnancy	40		Change in recreation	19	
Sexual difficulties	39		Change in church activities	19	
Gain of new family member	39		Change in social activities	18	
Business readjustment	39		Mortgage or loan less than $30,000	17	
Change in financial state	38		Change in sleeping habits	16	
Death of a close friend	37		Change in number of family get-togethers	15	
Change to different line of work	36		Change in eating habits	15	
Increase in arguments with spouse	35		Vacation	13	
Mortgage over $100,000	31		Christmas alone	12	
Foreclosure of mortgage or loan	30		Minor violations of the law	11	
Change in responsibilities at work	29		Total Score:		

FAMILY HISTORY:

Father: Age: __ Living ___ Deceased ___ Cause of Death: _____

If deceased, HIS age at time of his death: _____ YOUR age at time of his death: _____

His occupation: _____ His health: _____

Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: ___ Living ____ Deceased ____ Cause of Death: _____

If deceased, HER age at time of her death: _____ YOUR age at time of her death: _____

Her occupation: _____ Her health: _____

Frequency of contact with her: _____ Are you/Have you been close to her? _____

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Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?			
					No		Yes
					No		Yes
					No		Yes
					No		Yes

During your childhood, did you live any significant period of time with anyone other than your natural parents?

Yes_____ No _____

If Yes, please name the person and their relationship to you:

Name: _____ Relationship to you: _____

Please place a check mark in the appropriate box if these are or have ever been present in your relatives:

	Children	Mother	Father	Brother	Sister	Aunt/Uncle	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Suicide Completion							
Drinking Problem							
Illicit Drug Use Problem							
Unsafe Substance Use							
Anxiety							
Substance Abuse Treatment							
Medical Detox from alcohol or other drugs							

CONFIDENTIAL PATIENT HISTORY

SOCIAL HISTORY:

Past Marital History

Have you been married previously? Yes ____ No ____

If Yes, please provide details.

How many times? _____

When? _____ How long? _____

When? _____ How long? _____

Education History

Highest grade level completed: _____

Degree obtained, if applicable: _____

Did you have any disciplinary problems in school? Yes ____ No ____

If Yes, please explain: _____

Were you considered hyperactive, ADD, or ADHD in school? Yes ____ No ____

If Yes, were you on any medication? Yes ____ No ____

If Yes, which medication: _____

What kind of grades did you get in school? _____

Do you have a Religious affiliation? Yes ____ No ____

If Yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Trauma/Abuse History

Have you ever been abused? Yes ____ No ____

Verbally ____ Emotionally ____ Physically ____ Sexually ____ Neglected ____

If Yes, by whom? _____

Have you experienced a traumatic event? Yes ____ No ____

If so, please describe:

_____

_____

CONFIDENTIAL PATIENT HISTORY

LEGAL HISTORY:

Have you been arrested? Yes ____ No ____ How many times? _____

Are you currently on Probation? Yes ___ No ___ If Yes, who is your probation officer: _____

If Yes, please describe below:

Date	Charges (felony, misdemeanor) (DUI, reckless driving, possession)	State & County of incident	Sentence (jail, fines, probation, license suspended)	Outcome (charges dropped; time served)

EMPLOYMENT HISTORY

Are you currently employed? Yes ____ No ____

If Yes, name of employer: _____

What type of work do you do? _____

Do you feel financially secure? Yes ____ No ____ Explain: _____

Previous Employment

Employer (most recent first)	Dates	Reason for leaving

SUBSTANCE USE HISTORY:

Alcohol

Do you drink alcohol? Yes ____ No ____ If Yes, age of first use: _____ Date of last use: _____
How much alcohol do you drink? _____ How often do you drink? _____
Have you ever passed out from drinking? Yes ____ No ____ If Yes, how often? _____
Have you ever blacked out from drinking? Yes ____ No ____ If Yes, how often? _____
Have you ever had the "shakes" as a result of drinking? Yes ____ No ____ If Yes, how often? _____
Have you ever felt that you should cut down on your drinking or drug use? Yes ____ No ____
Have you ever been annoyed by people criticizing your drinking or drug use? Yes ____ No ____
Have you ever felt guilty or bad about your drinking or drug use? Yes ____ No ____

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Have you ever drunk or used drugs in the morning to steady your nerves or relieve a hangover? Yes ___No ___
Do you use tobacco? Yes ____ No ____ If yes, what type and how often? _____

Drugs

Please indicate for each drug listed below:

Drug	Age of 1st use	Route of use (oral, IV, snort)	Amount used	Frequency of use (social, daily, once a week, weekends.)	Last use of this drug
Marijuana					
Cocaine					
Crack					
Methamphetamine					
Heroin					
Synthetic Opiates (Oxy, roxy, fentanyl, morphine)					
Ecstasy					
Methadone					
Suboxone					
Benzodiazepines					
Barbiturates					
Hallucinogens (pcp, lsd, mushrooms)					
Huffing (Duster/Whippits)					
DXM-cough/cold medicine dextromethorphan					
Spice, Kratom, Bath Salts, etc.					
Other: _____					

Medical Marijuana

Are you a Medical Marijuana Card Holder? Yes ___ No ___

If Yes, For what condition? _____

If yes, who is the prescribing doctor? _____ Telephone #: _____

How long have you been taking this medication? _____

CONFIDENTIAL PATIENT HISTORY

What is the drug that has caused you the most problems? _____

Substance Abuse Detox and Treatment History

Date	Facility & Modality (outpatient, IOP, PHP, residential)	For what substance	Outcome (left AMA, completed program)	Length of sobriety after treatment

Are you in Recovery now? Yes ___ No ___ If yes, for how long? _____

Have you ever attended 12-Step Meetings? Yes ____ No ____ If yes, when? _____

Do you have a Sponsor? Yes ____ No ____

I CERTIFY ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Patient Signature **Date**

Signature of Clinician **Date**

CONFIDENTIAL PATIENT HISTORY

INFORMED CONSENT FOR VOLUNTARY ASSESSMENT AND/OR TREATMENT

I understand that I have voluntarily entered treatment or given my consent for the person under my legal guardianship to receive services at The Mindful Health Foundation.
I voluntarily consent to have treatment provided by a psychiatrist, registered nurse, psychologist, social worker, mental health counselor, dietitian, body image therapist, yoga instructor or intern in collaboration with a supervisor. The type and extent of services that I will receive will be determined following an initial assessment and thoroughly discussed with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.
I understand that all information shared with the clinicians at MHF is confidential and no information will be released without my consent. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to me or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I am aware that the practice of mental health counseling and the treatment involved are not exact sciences and that no guarantees have been made to me as a result of my treatment by or through MHF.
I understand that MHF does not warrant or agree to offer a care of rehabilitation, but merely to afford such treatment that the MHF normally gives other patients in similar circumstances. I agree to pay for services in full as outlined in my initial intake assessment. I authorize the MHF to act on my behalf with case management services that may include scheduling and billing. I understand that the individual practitioners may not be employees of The Mindful Health Foundation. If a legal complaint is made against an independent contractor, I agree to indemnify The Mindful Health Foundation and hold them harmless in all ways from any complaints or any type of legal claim made against the individual practitioners.
If I have any questions regarding this consent form or about the services offered at The Mindful Health Foundation, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by The Mindful Health Foundation. I understand that I may stop treatment at any time.

MHF & Advance Directives:

Under federal law, an advance directive is defined as: A written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated**. MHF only treats clients that can provide voluntary consent** to their treatment plan. If a client is unable to consent voluntarily, the client and the client's family will be referred to an appropriate provider.
I would like to be provided education material, a copy of the four-page advance directive from the Florida Baker Act Manual, and The Personal Safety Plan.

YES NO

CONFIDENTIALITY POLICY

All services rendered at The Mindful Health Foundation are confidential.

Anonymity Policy

As a patient of The Mindful Health Foundation, I agree to refrain from identifying, sharing information, or gossiping about any other patient in the program. All information in sessions is strictly confidential. This includes groups.

Release of Records

Under no circumstances will mental health records be released without a WRITTEN MHF consent.
There is a fee of $1.00 per page charged for photocopies.

Exceptions: The Mindful Health Foundation will coordinate the release of records to court/administrative agencies once a valid release is signed by the patient. The Mindful Health Foundation will update your referring provider monthly of your progress if a valid release is signed to facilitate continuity of care. We will correspond with your insurance company.

Types of Records Released

The Mindful Health Foundation releases records in accordance with Florida Statute 456.057. when a patient's psychiatric, chapter 490 psychological, or chapter 491 psychotherapeutic records are requested by the patient or the patient's legal representative, The Mindful Health Foundation will provide a report of examination and treatment in lieu of copies of records.

Phone Policy:

Unless we have a release from the patient, we will not confirm or deny that any patient attends The Mindful Health Foundation over the phone. this can be frustrating if you ask a friend or family member to contact us for scheduling or billing purposes. Please understand that without a release, we will not speak with anyone. This is done to protect your confidentially.

_____

PATIENT SIGNATURE **DATE**

_____

Clinician's Signature **DATE**

Please Review the following Notice of Privacy Practices

The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information, and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety. Below is a description of the privacy practices required by federal law to protect your personal information. A copy is provided in your client handbook.

Our Pledge Regarding Your Medical Information the Mindful Health Foundation (MHF) is committed to protecting medical information about you. We create a record of the care and services you receive at MHF for use in your care and treatment. This Notice tells you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to give you this Notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Medical Information about You. The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures we will describe them and give some examples. Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. The Mindful Health Foundation abides by all applicable state and federal laws related to the protection of this information. Not every use or disclosure will be listed. All the ways we are permitted to use and disclose information, however, will fall within one of the following categories. For Treatment. We may use medical information about you to provide you with mental health treatment or services. We may disclose medical information about you to staff with in our health system and personnel who are involved in taking care of you at MHF. For Payment. We may use and disclose medical information about you so that the treatment and services you receive at MHF may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about a service you received at MHF so your health plan will reimburse you for the service. We may also tell your health plan about a proposed treatment to determine whether your plan will pay for the treatment. For Health Care Operations. We may use and disclose medical information about you for MHF's operations. These uses and disclosures are made for quality of care and medical staff activities. Your medical information may also be used or disclosed to comply with law and regulation, for contractual obligations, patients' claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of MHF to another entity, underwriting and other insurance activities and to operate the health system. For example, we may review medical information to find ways to improve treatment and services to our patients. Appointment Reminders. We may contact you to remind you that you have an appointment at MHF. Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. Health-Related Benefits and Services. We may contact you to tell you about benefits or services that we provide. Disaster Relief Efforts. We may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. As Required by Law. We will disclose medical information about you when required to do so by federal or state law. To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat. Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illnesses. Public Health Disclosures. We may disclose medical information about you for public health purposes. Health Oversight Activities. We may disclose medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law. Legal Proceedings. We may disclose medical information to courts, attorneys and court employees in the course of conservatorship and certain other judicial or administrative proceedings. Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process. Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- about criminal conduct at MHF; and
- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. In most circumstances, we may disclose medical information to a coroner or medical examiner. This may be

Patient Initials _____ Date _____

necessary, for example, to identify a deceased person or determine cause of death. We may also disclose medical information about patients of MHF to funeral directors as necessary to carry out their duties. National Security and Intelligence Activities. As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities. Protective Services for the President and Others. As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state. Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. Right to Request an Amendment or Addendum. If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). Amendment. To request an amendment, your request must be made in writing and submitted to: Patient Relations Department, The Mindful Health Foundation 865 91st Ave. North, Naples, FL 34108. Phone: (239)434-6596 and Fax: (239)514-2519. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

In addition, we may deny your request if you ask us to amend information that:

• was not created by MHF;

• is not part of the medical information kept by or for MHF;

• is not part of the information which you would be permitted to inspect and copy; or

• is accurate and complete in the record.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to Patient Relations. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record. Right to an Accounting of Disclosures. You have the right to receive a list of the disclosures we have made of your medical information.

To request this accounting of disclosures, you must submit your request in writing to The Mindful Health Foundation, 865 91st Ave. North, Naples, FL 34108. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request in writing to the Patient Relations Department, The Mindful Health Foundation 865 91st Ave. North, Naples, FL 34108. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at work or only by mail. To request confidential communications, you must make your request in writing to the Patient Relations Department, The Mindful Health Foundation 865 91st Ave. North, Naples, FL 34108. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. Changes to Privacy Practices and This Notice. We reserve the right to change MHF's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. Questions or Complaints. If you have any questions about this Notice, please contact the Patient Relations Department, The Mindful Health Foundation 865 91st Ave. North, Naples, FL 34108. If you believe your privacy rights have been violated, you may file a complaint with MHF or with the Secretary of the Department of Health and Human Services.

To file a written complaint with MHF, contact the Patient Relations Department, The Mindful Health Foundation 865 91st Ave. North, Naples, FL 34108. *You will not be penalized for filing a complaint.*

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

I HEREBY CERTIFY that I have read and agree to the conditions.

Patient Initials Date

CONFIDENTIAL PATIENT HISTORY

YOUR RIGHTS AND RESPONSIBILITIES

You have the RIGHT to:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

You have the RESPONSIBILITY to:

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health. Intentionally misrepresenting information or withholding information that may impact your care can be grounds for discharge.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility at least 24 hours in advance.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient Initals **Date**

CONFIDENTIAL PATIENT HISTORY

IMPORTANT NUMBERS:

- CARF: 6951 East South point Road Tucson, AZ 85756-9407. Toll free (866) 510-2273 or (866) 510-CARF, which is a dedicated telephone line for receiving public feedback during business hours. (Other business calls should continue to be directed to CARF's main number.)
- Department of Children & Families: Mr. Jacob N Still, Senior Human Program Specialist. Department of Children and Families -Sun Coast Region. Substance Abuse Mental Health Program Office, 1864 17th St Sarasota FL 34234, Phone: (239) 338-1225

MHF PROGRAM RULES

1. I am voluntarily entering treatment at The Mindful Health Foundation. (You may have a court requirement that you are required to fulfill but engaging in treatment at MHF is your choice).
2. I AGREE TO BE ALCOHOL AND DRUG FREE WHILE ENROLLED IN SERVICES AT MHF. I understand that this is a drug/alcohol-free program. I am willing to notify staff if another client is under the influence of alcohol or drugs or is dealing drugs. Presenting to treatment under the influence may be grounds for immediate discharge.
3. I agree to attend all scheduled appointments on time.
4. I understand that disagreements among clients and/or staff do occur and that physical fighting or threats are never permitted. Aggressive behavior including but not limited to cursing at others, slamming doors, throwing objects, verbal abuse, or hostility to anyone including patients, staff, and other practitioners is grounds for immediate discharge. You are allowed to be angry, but you are not allowed to verbally attack others. I agree to all the rules of group therapy and to treat other patient's with respect.
5. If I desire to leave this program prematurely, I agree to talk to my therapist about the issues or problems that are encouraging that decision.
6. I accept responsibility for the cost of the program.
7. I have received a copy of the Patient handbook, including the Florida Patient Bill of Rights and accepted them as presented to me. I understand that all efforts will be made to respect my rights as a person and client.
8. I agree to protect the anonymity of other group members, and I must not disclose to outside sources the identity of other group members or give any information that may identify a person as being in treatment with me.
9. I understand that I retain all legal and civil rights during the period of my treatment.
10. I agree to not contact other patients or staff via social media. I agree to not engage in any type of relationship with another patient admitted to The Mindful Health Foundation (friendship or otherwise) outside of the confines of treatment.
11. I agree to not post, share, utilize, re-post, text, instant message, email, or verbally disclose any information, names, or details shared in sessions about other patients or staff members to anyone. This includes information found on the internet, and Social Media, such as Facebook, Instagram, Snapchat, and Twitter. The Mindful Health Foundation believes that both staff and patients have a right to privacy, and a safe and healthy treatment environment. The Mindful Health Foundation has a no tolerance policy for bullying including cyber bullying.
12. I understand that if one or more of these program rules are not adhered to; this may result in make-up sessions, dismissal, suspension from treatment, and /or referral to another treatment modality.

PATIENT SIGNATURE **DATE**

Clinician's Signature **DATE**

CONFIDENTIAL PATIENT HISTORY

HIV/AIDS FACT SHEET

What are HIV and AIDS? HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006.HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

AIDS is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS.

How is HIV spread? HIV is spread primarily by:

- Not using a condom when having sex with a person who has HIV. All unprotected sex with someone who has HIV contains some risk
- Having multiple sex partners or the presence of other sexually transmitted diseases (STDs) can increase the risk of infection during sex. Unprotected oral sex can also be a risk for HIV transmission, but it is a much lower risk than anal or vaginal sex.
- Sharing needles, syringes, rinse water, or other equipment used to prepare illicit drugs.
- HIV can be passed from mother to child during pregnancy, birth, or breast-feeding.

Less common modes of transmission include:

- Being "stuck" with an HIV-contaminated needle or other sharp object. Receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV.
- HIV may also be transmitted through unsafe or unsanitary injections or other medical or dental practices. However, the risk is also remote with current safety standards in the U.S.
- Eating food that has been pre-chewed by an HIV-infected person.

CONFIDENTIAL HIV RISK SCREENING

This screening is for your information and will not be shared with anyone. If you check any of the following, it is a good idea to get tested. Your counselor will provide you with a testing site. In the past 90 days:

1. Have you shared unclean needles or syringes with someone? □ YES □NO □DON'T KNOW
2. Have you had unprotected sex with anyone (male, female, transgender)? □ YES □NO □DON'T KNOW
3. Have you had sex with someone whose HIV status you did not know? □ YES □NO □DON'T KNOW
4. Have you had sex with someone whose HIV status you knew was different from yours? □ YES □NO □ I DON'T KNOW
5. Have you been diagnosed with Syphilis, Chlamydia, or Gonorrhea? □ YES □NO □DON'T KNOW
6. Have you had sex while high on drugs or alcohol? □ YES □NO □DON'T KNOW
7. Have you exchanged sex for money, drugs, shelter, etc.? □ YES □NO □DON'T KNOW
8. If you are HIV-positive and have been prescribed HIV medication, have you had trouble taking your HIV medication as prescribed by your doctor? □YES □NO □DON'T KNOW

CLIENT REFERRED TO TESTING SITE?

□YES, □NO □PROVIDED POST TEST COUNSELING

Patient Signature **Date**

Signature of Clinician **Date**

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CONFIDENTIAL PATIENT HISTORY

TUBERCULOSIS RISK ASSESSMENT-Persons with any of the following risk factors are candidates for tuberculin testing. Testing is provided by the Collier County Health Department located at 3301 Tamiami Trail E. Building H, Naples FL, 34112. Telephone Number: 239-252-8200

Risk Factor	Yes	No
Recent close or prolonged contact with someone with infectious TB disease.		
Foreign-born person from or recent traveler to high-prevalence area such as Africa, Asia, Southeast Asia/Pacific Islands, Middle East, Central and South America and /or Eastern Europe		
Chest radiographs suggesting inactive or past TB		
HIV infection		
Organ transplant recipient		
Immunosuppression secondary to use of prednisone (equivalent of ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication such as TNF-α antagonists		
Injection drug user		
Resident or employee of high-risk congregate setting (e.g., prison, LTC facility, hospital, homeless shelter)		
Medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for given population])		
Signs and symptoms of TB including unexplained weight loss, elevation of temperature for more than one-week, unexplained night sweets, unexplained persistent cough for more than 3 weeks, unexplained cough with productive bloody sputum.		

Adapted from http://www.cdc.gov/tb/publications/LTBI/appendixA.htm

☐ **CLIENT WAS REFERRED FOR TESTING.** ☐ **CLIENT WAS NOT REFERRED.**

RELEASE FOR REPORTING COMMUNICABLE DISEASES

The public health system depends upon reports of disease to monitor the health of the community and to provide the basis for preventive action. Your signature will authorize a release for reporting communicable diseases to the Collier County Health Department.

These conditions are generally rare and include but are not limited to:
Acquired Immune Deficiency Syndrome (AIDS), Amebic Encephalitis, Amebiasis, Animal bite, Anthrax, Botulism, Brucellosis, Campylobacteriosis, Chancroid, Dengue, Encephalitis, Gonorrhea, Granuloma, Inguinale, Hansens Disease- Leprosy, Hemorrhagic Fevers, Hepatitis, Histoplasmosis, Legionnaires Disease, Leptospirosis, Lymphogranuloma, Berereurn, Malaria, Measles, Meningitis, Meningococcal Disease, Mumps, Paralytic Shellfish, Poisoning, Perstussis, Pesticide Poisoning, Plague, Pliomueltits, Psittacosis, Rabies, Relapsing Fever, Rubella, Salmonellosis, Shigellosis, Smallpox, Syphilis, Tetanus, Toxoplasmosis, Trichomonas, Tularemia, Typhoid fever, Typhus, Vibrio Cholera, Vibrio Infections, Yellow Fever

Patient Signature **Date**

Clinician Signature **Date**

2023 Revised Intake

CONFIDENTIAL PATIENT HISTORY

PAYMENT POLICY

Thank you for choosing us as your mental health provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request & is available on our website: THEMINDFULHEALTH.COM

Insurance. We participate in BC/BS, Meritain, Community Health Partners United Behavioral Health (IOP and PHP only) and Aetna plans. If you are not insured by a plan we do business with, payment in full is expected at each visit, or an active payment plan needs to be on file. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-Covered Services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit. The following services, unless included as part of your Intensive Outpatient or PHP treatment, will not be covered in an outpatient level of care, and you will be responsible for the fees: nutrition services, art therapy, body image therapy, meal support career counseling, and movement therapy groups. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission: We will submit your in- network claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment: If your account is over 60 days past due, you may be referred to a collections agency and may incur collection fees consistent with the maximum allowable rate in Florida. Partial payments will not be accepted unless otherwise negotiated in a payment contract. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice.

Missed Appointments: Insurance companies do not cover for missed appointments. Our policy is to charge a standard fee for missed appointments not canceled twenty-four hours prior to your service. The missed appointment fee is $35.00 for outpatient services and this does include group therapy. The missed appointment fee IOP or Day/PHP treatment is $100.00 per day. IOP and PHP treatment requires a minimum number of hours of attendance per week and if you are unable to attend those hours, you will be discharged from the program. MHF will accept a written medical note to excuse a missed appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. You may notify MHF of any schedule changes by calling (239) 434-6596.

Returned Check Policy: Returned checks are costly to you and us. Not only will your bank charge you, we will charge you a fee of $25 and insist on cash or credit card in the future.

Out of network/ Cash Pay: Mindful Health is not a provider with United Health (OUTPATIENT SERVICES), Cigna, Medicare, Tricare or Medicaid. Fees for services will be collected at the time of service for initial intakes and outpatient services. Fees for Intensive Outpatient, PHP Treatment will be collected at the beginning of each treatment month and require a written payment agreement and credit card on file. As a courtesy, Mindful Health will submit your claims and your insurance will reimburse you per your plan.

Medicare: Medicare does not reimburse for out of net-work services. We are not a Medicare provider. The Mindful Health Foundation will not file claims, appeals, etc. if you are covered by any type of Medicare plan. Your services will be charged directly to you.

Fees for Service:

Diagnostic Evaluation- $175.00
Individual therapy, 60 mins. $125.00
Family Therapy- $175.00 (75 MINS)
Group Therapy- $50.00
Group Alcohol & Drug Counseling- $30.00
Individual Alcohol & Drug Counseling- $80.00

Alcohol & Drug Assessment- $60.00
Urine Drug Screen- $35.00
IOP Day unit $350.00
PHP DAY UNIT $750.00

Non-Covered Outpatient Services:
Initial Nutrition Assessment-$175.00
Nutrition follow up- $75.00
Individual Art Therapy- $125.00
Art Therapy Group, 120 minutes- $60.00
Movement therapy Group- $25.00

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

I have read and understand all of the above policies. By signing below, I verify that I understand and agree to comply with these policies and that all questions have been answered sufficiently.

Signature of Patient/ Guardian **Date**

CLINICAN'S SIGNATURE **DATE**

CONFIDENTIAL PATIENT HISTORY

INITIAL TREATMENT PLAN

MHF will assess for the severity of the level of impairment to your functioning to determine appropriate level of care (e.g., the behaviors noted create mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors) ; continuously assess this severity of impairment as well as the efficacy of treatment. MHF team will also assess the level of insight (syntonic versus dystonic) toward the presenting problems.

PATIENT WILL COMPLETE:

- ☐ An Individualized Treatment Plan
- ☐ Psycho Social Assessment
- ☐ Substance Abuse Screening
- ☐ Mood Disorder Assessment
- ☐ Beck Depression Inventory
- ☐ Beck Anxiety Index
- ☐ Nutrition Assessment
- ☐ BASIS-32
- ☐ EDI- 3
- ☐ Nursing Assessment
- ☐ Medical Evaluation (by referral)
- ☐ Psychiatric Evaluation
- ☐ Case Management Assessment
- ☐ Eating Disorder Questionnaire
- ☐ Recreational Evaluation

TARGET DATE FOR SHORT-TERM OBJECTIVES:

☐ 30 Days

☐ 7 Days

_____

Signature of Patient/ Guardian **Date**

_____

Signature of Clinician **Date**

_____

Signature of Licensed Supervisor **Date**

CONSENT FOR URINE DRUG SCREEN

I, _____ as a patient of MHF, consent to allow my urine to be tested for drugs/alcohol. I further consent to allow the results of such testing to be released to all members of treatment team to assist in the continuity of my care at MHF.

I understand that my records are protected under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR part 2 and Florida Statutes (FS 90, 503.90.5035, chapters 381,382,383,384,390,391,392,393,394,395,397,415,445,490,491 and 45 CFR 160-164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____

Signature of Patient/ Guardian **Date**

_____

Signature of Clinician **Date**