

Patient Intake Form / Consents

Did you find this provider's profile via Alma, Grow Therapy, or Headway?

Client Age Range

Client Demographic Information

Client First Name: Client Middle Name: Client Last Name: Date of Birth:

Client's Legal Name

Marital Status Gender Assigned at Birth: Gender Identity Pronouns

Client Cell Phone: Client Home Phone: Client Work Number

Client Email:

Preferred Language Race Ethnicity

Street Address Apt / Unit #

City State Zip Code

Pharmacy Name

Pharmacy Address: Pharmacy Phone Number:

Emergency Contact Name

Emergency Contact Relationship Emergency Contact Phone

Primary Care Provider Name Primary Care Provider Number

Chief Complaint:

Allergies to Medications

Medication Allergies	Medication Name	Reaction	Comments
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Current Medications (Psych Meds & Non-Psych Meds)

	Medication Name	Dose	Comments
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When was the last time you saw your primary doctor?

Do you give us permission to speak to your Primary Care Provider (PCP) or Former Psych Provider regarding your treatment and/or they can speak to us regarding your medical information?

PSYCHIATRIC TREATMENT HISTORY

Current or Past Psychiatric Diagnoses (diagnosed by a provider/therapist)

Family Psychiatric History

No items selected

Psychiatric Medication Trials	Medication Name	Dose	How Taken	How long taken?	Effective?	Comments
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Personal History

Substance Use History Comments: Any experience with substance uses in the past or current use?

Currently suicidal?

Tell us about therapy you've had in the past, if any.

Legal History

Legal Issues

Legal History Comments

Military History

Military Information

Military History Comments

Work History

Current Employment

Current Occupation

Work Concerns

Work Comments

Sexual History

Sexuality

Sexually Active

Birth Control Method

Sexuality Comments

Have you had routine labs done in the past year?

Do you have any type of insurance?

Screening Assessments

There are two screening tools inserted into this intake form.

Please answer them all so we can get a better understanding of how to help you.

INSURANCE INFORMATION

Clients identified areas for improvement/outcomes (What are your goals for therapy?)

Please attach a picture of the front of a picture ID - either Driver's License, State ID, or passport. If the patient is a minor, please attach the parent's ID. No controlled substances will be prescribed without a picture ID.

No files were attached

Acknowledgement and Consent to Contact

By entering in this information, you acknowledge that it will be sent via secure email. You are giving us your consent to contact you via email, text messages, and by phone as needed. By signing this form you are giving us consent to this information and the ability to contact you.

Signature of Patient / Parent / Authorized Representative

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If you have indicated that we can speak to your Primary Care Provider (PCP) regarding your treatment and/or they can speak to us, please fill out and sign the Release of Information attached to this intake.

PSYCHIATRIC TREATMENT HISTORY



The Vine Health Services
90 Millburn Avenue, Suite 203,
Millburn, NJ 07040
(973)-432-9621
info@thevinehealth.org
thevinehealth.org

Welcome to The Vine Health Services

We appreciate you taking a moment to read this. We wanted to thank you for choosing us to provide for your primary care or mental health and wellness needs and goals. We appreciate and acknowledge the courage it takes to want to make a change, and we are delighted, honored, and privileged to be working with you through this journey.

We are a holistic primary care and mental health and wellness private practice that offers a range of treatment modalities tailored to the needs of our clients. We are dedicated to helping individuals explore and overcome things holding them back from reaching their full potential and enjoying life. We partner with clients to help them achieve satisfaction and success in their lives by giving our clients the tools they need to overcome medical and psychological hardship and ultimately feel empowered in their wellness journey.

Often our clients want to share with others their progress and success. You will have the most success by completing the goals you came to achieve. We welcome you to share your progress with others. Please know that should you choose to refer a potential client to work with us that both of your information is confidential and protected under HIPAA guidelines. The Vine Health Services does not share information with others without your consent.

We very much welcome and appreciate new clients into our practice, so we can also help them achieve the goals that matter to them most. We look forward to getting started with you at your first appointment. Please kindly complete our intake package before your first appointment so we can get started. Should you have any questions before our meeting, please feel free to give us a call.

Warmly,

The Vine Health Services

Mental Health and Wellness Treatment Agreement

Policy and Consent

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in mental wellness treatment may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in mental wellness treatment can lead to a greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of mental wellness treatment.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. The journey to mental wellness is a marathon, not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the process, we identify goals, review progress, and modify the treatment plan as needed.

SERVICES: You agree to receive psychotherapy, and medication management if needed which may involve the off-label use of medications. You understand the risks, benefits, and alternatives of receiving these services and have had the opportunity to ask questions.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment within 48 hours of the scheduled appointment time or you will be charged a \$100 fee for new patients and a \$50 fee for existing patients.*** If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time.

FEES/INSURANCE: We are in network. We work with United Health/Optum, United Community Plan, Horizon Blue Cross Blue Shield, Cigna, Amerihealth, Aetna, Humana, Wellpoint, Wellcare, Medicaid, and Medicare.

If your insurance is not listed above, you can still pay out of pocket. If you are paying out of pocket, you will be charged the day of your session **before** your session time. The acceptable form of payment is a credit/debit card on file. In the event that a scheduled appointment time is missed or canceled less than **48 hours**, please refer to the "Appointments and Cancellations" policy above. Any **late cancellations or no-shows will result in the client being charged a \$100 fee for new patients and a \$50 fee for existing patients.**

If you are paying out of pocket, we can provide you with an itemized receipt/superbill that may allow you to get reimbursement from your insurance company usually between 60-80% after your deductible is met. The clinician reserves the right to terminate the treatment relationship if more than 3 sessions are missed without proper notification.

The clinician bills insurance in quarter hours for phone calls over 15 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records; the cost is \$25.00. Payment for your medical records will be due prior to or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are Monday through Friday, Saturday hours vary. If you need to contact the clinician for any reason please text or call (908) 777-1617, leave a voicemail, and a return call will be made as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. Text HOME to 741741 from anywhere in the United States, anytime, about any type of crisis. Crisis Text Line serves anyone, in any type of crisis, providing access to free, 24/7 support and information via a medium people already use and trust: text. If either you or someone else is in danger of being harmed, dial 911 or go to your nearest emergency room.

Anything said in mental health and wellness treatment is confidential and may not be revealed to a third party without written authorization, **except** for the following limitations:

- **Child Abuse:** Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child-on-child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, we are required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse:** Vulnerable adult abuse or neglect. If information is revealed about a vulnerable adult or elder abuse, we are required by law to report this to the appropriate authority.
- **Self-Harm:** Threats, plans, or attempts to harm oneself. We are permitted to take steps to protect the client's safety, which may include the disclosure of confidential information.
- **Harm to Others:** Threats regarding harm to another person. If you threaten bodily harm or death to another person, we are required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas:** If we receive a subpoena for your records, we will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. We will contact you twice by phone. If we cannot get in touch with you by phone, we will send you written correspondence. If a court of law issues a legitimate court order, we are required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, we are required to comply with a court order.
- **Law Enforcement and Public health:** A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities:** To an appropriate agency, information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services or specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

- **Victim of a Crime:** Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court-Ordered Therapy:** If treatment is court-ordered, the court may request records or documentation of participation in services. We will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request:** Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If mental health and wellness sessions involve more than one person, each person over the age of 18 **MUST** sign the release of information before the information is released.
- **Fee Disputes:** In the case of a credit card dispute, we reserve the right to provide the necessary documentation (i.e. your signature on the "Credit Card on File" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on the account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. We request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the couple's therapy goal. If one partner requests that we keep a "secret" in confidence, we may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Social Media:** In a digital modern world we use our professional social media platforms to advocate for mental health and wellness while providing educational information. Social media should not replace mental health and wellness treatment. No friend requests on our **personal** social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) if you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. We cannot be held liable if someone identifies you as a client. Please do not contact us through any social media site or platform. They are not confidential and may become part of a medical record.
- **Electronic Communication:** Any electronic means of communication bears the risk of being intercepted. Our office does not communicate via email because it becomes harder and harder to keep emails secure and confidential. Furthermore, if you send an email from a work computer, your employer has the legal right to read it. Emails sent to our office may be made a part of your medical record.

Please contact our office through the [Spruce app](#) if you would like to reach your provider by electronic means. You **MUST text inside of the application for it to remain confidential**. Please be aware that these texts are screened by our office staff and are often resolved without the provider being contacted directly. If you are experiencing issues that need to be addressed by your provider, and they are not life-threatening emergencies, please schedule an appointment to discuss these matters further. Text messages can not replace therapy sessions or missed appointments. Do not email, text, or leave a voicemail if you are experiencing a life-threatening event. Call 911, or go to your nearest emergency room.

1. I have read and understand the information contained in the **The Vine Health Services Agreement, Policy, and Consent**. I have discussed any questions that I have regarding this information with my **The Vine Health Services Clinician**. My signature below indicates that I am voluntarily giving my informed consent to receive Mental Health and Wellness services and agree to abide by the agreement and policies listed in this consent. I authorize my **The Vine Health Services Clinician**

clinician to provide counseling services that are considered necessary and advisable.

2. If a "super bill" is requested I authorize the release of treatment and diagnosis information necessary to process "super bills" for services to my insurance company, I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **The Vine Health Services Clinician** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

Your signature signifies that you have received a copy of the "Mental Health and Wellness Treatment Agreement, Policies and Consent" for your records.

Updated: 5/1/2023

Client's Printed Name:

Client's Legal Representatives Name: _____

If client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature

Date

TELEHEALTH CONSENT, POLICY, and AGREEMENT

This form is in addition to the regular Mental Health and Wellness, Policies, Agreement, and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Telehealth sessions.

Required Information at Every Visit

- Name, location, and telephone number of the patient at the time of session. This is to ensure that your practitioner is aware of alternative means of treatment should an emergency occur.
- Name, location, and telephone number of the provider at the time of session.

Telehealth incorporates email, phone, and video technology. This is to inform you about what you can expect regarding your participation in Telehealth.

Benefits: The benefits of Telehealth are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from an office.
4. Ability to have real-time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients, clients with limited mobility, and clients without convenient transportation options.

Limitations: It is important to note that there are limitations to Telehealth that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. Due to technology limitations we may not hear all of what you are saying and may need to ask you to repeat things.
2. Technology might fail before or during the telehealth session. Our second line of communication will be via telephone.
3. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
4. To reduce the effect of these limitations, we may ask you to describe how you are feeling, thinking, and/or acting in more detail than we would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics: When we provide phone/video counseling sessions, we will call you at our scheduled time or send you a link for our secure and HIPAA-compliant platform such as Doxy.me, Spruce, or ZOOM. We expect that you are available at our scheduled time and are prepared, focused, and engaged in the session.

We are calling you from a private location where we are the only person in the room (unless otherwise discussed), you also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others who can hear you, we cannot be responsible for protecting your confidentiality.

Every effort **MUST** be made on your part to protect your own confidentiality. We suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that we cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines, we can only practice in the state(s) we are licensed. That means wherever you permanently reside we must be licensed. You agree to inform us if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Video Sessions: If we lose our connection during a video session, we will call you to troubleshoot the reason we lost connection. If we cannot reach you, we will remain available to you during the entire course of our scheduled session. Should you contact us back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss of connection is a result of something on our end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, we will call you back immediately. If we are unable to reach each other due to technological issues, we will attempt to call you twice. If we cannot reach you, we will remain available to you during the entire course of our scheduled session. Should you contact us back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss of connection is a result of something on our end, we will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Safety: If we have concerns about your safety at any time during a phone session, we will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in Telehealth Sessions: By signing below, you agree that you have read and understand all of the above sections of Telehealth Consent, Policy, and Agreement. You agree that you also understand the limitations associated with participating in Telehealth sessions and consent to attend sessions under the terms described in this document.

Recording of Sessions: In some instances, recording of the session may be utilized. Some providers use dictation software that records the session and then documents the session notes into the electronic medical record. This software is HIPAA compliant, and your information is private and confidential. At other times, recording of sessions may be done for educational purposes. Do you approve of the recording of your sessions with your provider? Yes No

Client's Printed Name:

Client's Legal Representatives Name: _____

If client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature Date

If client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature Date



The Vine Health Services
90 Millburn Avenue, Suite 203,
Millburn, NJ 07040
(973)-432-9621
info@thevinehealth.org
thevinehealth.org

No Show / Cancellation / < 48 Hrs Reschedule Policy

(PLEASE READ CAREFULLY)

When you cancel or reschedule less than 48 hrs prior to your appointment, or do not show up for your appointment, you prevent someone else from seeking treatment. You also place a financial burden on the practice. As a small practice, we can't stay in business and provide care, if patients repetitively miss, reschedule at the last minute, or continuously cancel appointments. We hope that you understand why we have to put this policy in place.

Multiple reminders, in different modalities, are sent to you to remind you of your upcoming appointment. If you must cancel or reschedule an appointment, we require at least 48-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. We do offer video/online appointments.

If you do not show up to your appointment, you will not get any refills until you see your provider.

In ONE calendar year - after the **second** less-than-48-hour cancellation, less-than-48-hour reschedule, or failure to show up to an appointment you **will be placed on a waiting list. You will not be able to self-schedule for three visits.**

A waitlist means you will be scheduled on a day to come in with other wait-listed patients. You will be worked in between other patients on the schedule. This will be on a first-come, first-served basis. There is no guarantee of how long you will have to wait to be seen. No refills will be called in until the provider sees you.

TERMS FOR DISCHARGE FROM THE PRACTICE: Within one calendar year - THREE (3) - less than 48 hr cancellations, less than 48 hr rescheduling of your appointment, or failure to show up to your appointment. Will be grounds for dismissal from the practice with a referral to another practitioner.

Client's Printed Name:

Client's Legal Representatives Name: _____

If client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature

Date

Health Information Portability and Accountability Act (HIPAA)

Notice of Privacy Policy

This document contains important information about federal law, the Health Information Portability and Accountability Act (HIPAA), which provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) used for treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for the use and disclosure of PHI for treatment, payment, and healthcare operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that we obtain your signature acknowledging that we have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion before signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it.

Use and Disclosure of Protected Health Information:

- ***For Treatment*** – We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another healthcare provider, we will have you sign an authorization for the release of information. Furthermore, authorization is required for most uses and disclosures of psychotherapy notes.

- ***For Payment*** – We may use and disclose your health information to obtain payment for services provided to you.

- ***For Operations*** – We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

For HIV Disclosure– Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, public health authorities are authorized to collect and receive private health information "for the purpose of preventing or controlling disease" and in the "conduct of public health surveillance..." without patient or provider consent or authorization other than state or local public health law. *This clause authorizes providers to report HIV/AIDS cases to the HIV Epidemiology Program without obtaining patient consent and it authorizes health department personnel to review medical records and any other source of information needed to report the case.*

Any other disclosure of HIV-related information must be made on the "*HIPAA- Compliant Authorization for Release of Medical Information and Confidential HIV-Related Information*". State law prohibits any further disclosure of HIV-related private health information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Client Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race,

ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and the release of information must be completed. Furthermore, there is a copying fee charge of \$25.00. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right to review them, which we will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, we will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with us. If you wish, we will provide you with the names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us in session before terminating or at least contact must be made by phone letting us know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not we think releasing the information in question to that person or agency might be harmful to you.

Clinician Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices concerning PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice

in the office during our session.

Client's Printed Name:

Client's Legal Representatives Name: _____

If the client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature

Date

DISCHARGE / TERMINATION FROM PRACTICE POLICY

The following situations are grounds for termination or discharge from **The Vine Health Services**. Should the following occur, your provider will no longer be able to continue providing your mental health care; accordingly, it will be necessary for you to transfer your care to another mental health provider.

- Ongoing pattern for missed or canceled appointments
- Negative findings on the Prescription Drug Monitoring Program website
- Inappropriate use of prescribed controlled substances
- Failure to follow the recommended treatment plan or medical instructions
- The provider cannot provide the level of care necessary to meet the client's needs
- The provider is relocating outside the service area
- The Client and/or Client's family is abusive to the provider and/or practice staff, or poses a serious threat of harm to the provider, staff, and/or other patients.

In the event of discharge or termination from **The Vine Health Services** the following will occur:

- The client will be notified in writing of the discharge/termination from **The Vine Health Services** via the patient portal and/or USPS mail.
- The client will be provided with an adequate supply of medication.
- The client will be instructed to find a new provider. A brief list of resources will be provided.

Client's Printed Name:

Client's Legal Representatives Name: _____

If the client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature

Date

Drug Screening Policy

I Jeannett Jacome hereby agree to submit to routine or random drug screenings per my provider's request. I understand that this is a requirement for any patient who is currently prescribed controlled substances or considering alternative treatment. My provider may require me to submit to a urine drug screen prior to beginning a new medication or at random, or for continuity of care. If at any time I refuse to submit to a drug screen, my provider may alter my treatment plan, or discharge me from services based on non-compliance.

_____ I understand that at any time, drug screens may be sent to an outside laboratory for confirmation.

_____ Any abnormal results will be addressed by my provider at my next appointment and may result in a modification of my treatment plan.

_____ Reoccurring abnormal results may require further action by my provider and or discharge from services.

_____ I understand that I may refuse a drug screen, but in doing so may have my treatment plan altered or potentially be discharged from services.

Updated: 5/1/2023

Client Printed Name: _____

Clients Representative Printed Name: _____

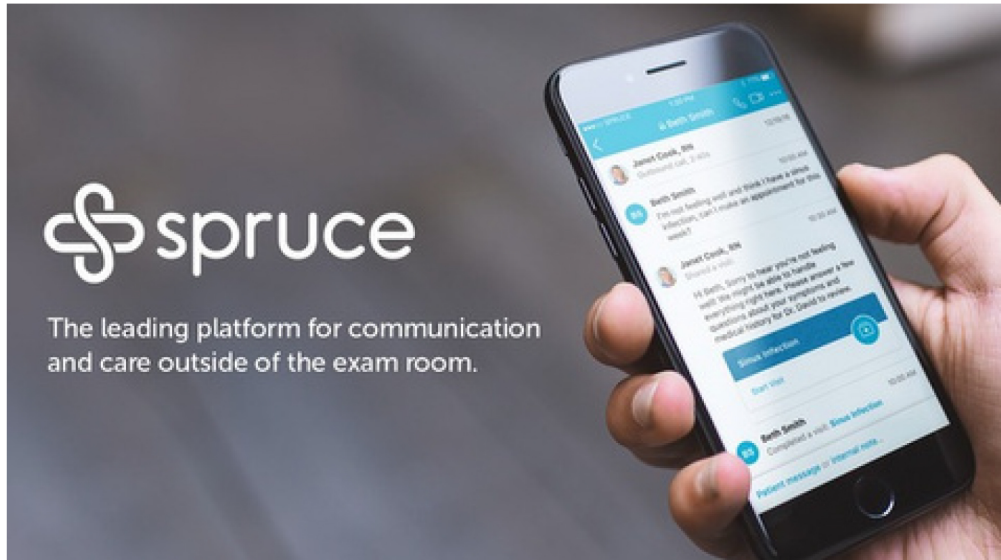
If the client is a minor / has a guardian:

Parent / Guardian Printed Name: _____

Signature

Date

● IMPORTANT ● COMMUNICATION



In order to communicate securely with our practice, you must download the Spruce app on your phone.

This allows us to keep your medical information private and allows you to communicate with us easily - just send us a text through the app.

**Please click the link
or scan the code below:**

<https://spruce.care/blessedfcmw>



Psychiatric Advance Directives: Taking Charge of Your Care

An advance directive is a written document that expresses your wishes in advance about what types of treatments, services and other assistance you want during a personal mental health crisis. A directive provides a clear statement of your medical treatment preferences and other wishes or instructions. You can also use it to grant legal decision-making authority to another person to be your advocate and agent until the crisis is over.

What Are The Benefits Of Having An Advance Directive?

A psychiatric advance directive can:

- Promote your autonomy and empowerment;
- Enhance communications between you, your doctor, treatment team and family;
- Protect you from ineffective, unwanted or possibly harmful treatment or actions;
- Help prevent crisis situations and reduce the use of involuntary treatment or safety interventions, such as restraint or seclusion.

When Will I Need An Advance Directive?

An advance directive goes into effect if you are hospitalized and it has been determined that you lack the capacity to make decisions for yourself. By writing your advance directive when your capacity is not in question, you have the opportunity to better influence what happens during a hospital stay. In an emergency situation, however, it is important to understand that doctors retain the authority to make decisions that are deemed necessary to ensure your safety and that of other patients and hospital staff.

What Should A Psychiatric Advance Directive Include?

You can include the medications and dosages that you know are most helpful to you and those that you do not wish to receive; names of facilities or healthcare professionals you want involved in your care, and people who can help you with important activities (such as paying your bills, and taking care of your children, pets or plants). You can also even identify the people you do or do not want as visitors if you're hospitalized.

One of the more powerful features of an advance directive is your ability to designate someone else (an agent) to make decisions for you if you are admitted to a hospital. You can name that person by stating that only he or she should make decisions for you in the event that you have been determined to lack the capacity to do so.

Duke University maintains a [national resource center](#) on psychiatric advance directives that provides background information and a guide to laws in each state.

Who Should Be My Agent?

The person you select should be someone you trust to advocate for you - a family member or friend. He or

she will tell others what kind of treatment you do or do not want, and supervise your care. You may wish to choose more than one agent. You can make one the primary agent and designate another as a back up, or you could give each person different responsibilities. Perhaps you trust one person to make your healthcare decisions and another to take care of your household matters (bills, etc.). Be clear about who should do what.

Before naming an agent, discuss your plans with the person(s) you want to designate. Each of them must fully understand your request.

Do I Need A Lawyer To Prepare An Advance Directive?

State laws vary. To maximize the enforceability of your advance directive, you may wish to consult with an attorney or someone from your state's protection and advocacy (P&A) program to see what your state allows. To find the P&A system in your state, visit the [National Disability Rights Network](#).

Who Should Have A Copy Of My Advance Directive?

It's important that people know you have an advance directive and know where to find it. Put a copy in your home where it can be easily found; and, put another one in a safe place with your other important papers. Be sure to give copies to people you trust - your agent or a trusted friend or relative; you should also have one on file at any hospital where you have been a patient before.

Can I Change My Mind?

You can change the contents of your advance directive by making corrections or writing out a new one. However, it is your responsibility to ensure that everyone has a copy of your most current advance directive.

Depending on where you live, you can also choose to make your advance directive revocable. This means you can reserve the right to cancel your advance directive even during a crisis. This must be stated in writing. However, if you choose to revoke your advance directive, your agent will no longer be able to advocate for you. Before you decide whether to make your advance directive revocable, you should thoroughly discuss this with your friends, family and healthcare providers.

Where Can I Find More Information?

Mental Health America's [It's My Life - Social Self-Directed Care](#) program provides information and educational videos about Psychiatric Advance Directives for consumers, providers and family members.

Resource:

"Psychiatric Advance Directives: Taking Charge of Your Care." Mental Health America,
<https://mhanational.org/psychiatric-advance-directives-taking-charge-your-care>.

Credit Card on File Consent

Information to be Completed by Cardholder:

The undersigned agrees and authorizes Blessed Family Care & Mental Wellness to save the credit card on file as entered into this document or into my electronic health record.

- I authorize Blessed Family Care & Mental Wellness to process the credit card as “Card on File”. I understand this authorization will remain in effect until the expiration of the credit card account which will require an updated card to be placed on file. Clients may also revoke this form by submitting a written request to Blessed Family Care & Mental Wellness at the address above. If a charge is processed to the card on file and declined, the client will be billed for any fee(s) associated with the decline of the credit card. The card on file will be used to pay for co-pays, co-insurances, no-show fees, and any other balances due on the client's account. There will not be an invoice sent out prior to the card being charged. The card will be charged for the full amount due, before or after the charge is incurred.
- I understand that if the invoice sent to me prior to my appointment is not paid 24-hrs before my appointment, Blessed Family Care & Mental Wellness will charge the amount due to my credit card on file.
- I further understand that if there is a balance due after my insurance pays for my visit, my credit card on file will be charged for that balance without prior notification. This is not “balance billing,” Balance due would be considered the patient responsibility noted on your Explanation of Benefits from your insurance company.
- I acknowledge that I am an authorized user of the card being used, or I have been given permission to utilize the credit card. If a fraudulent accusation results as a result of using this card, Blessed Family Care & Mental Wellness will cooperate with the authorities to prosecute any illegal activity. Please make sure you have the permission of the cardholder to use the credit card on file.

Client's Printed Name:

Client's Legal Representatives Name: _____

If client is a minor / has a guardian: Parent / Guardian Printed Name: _____

 CREDIT CARD INFORMATION

Name on Card

Credit Card Number

Expiration Date

Security Code

Postal Code

Signature

Date