NEW PATIENT PAPERWORK PACKET

NORTH AMERICAN MENTAL HEALTH SERVICES

CONSENT TO TREAT

To be completed by the patient, legal guardian, or conservator

Patient Information:
Name of Patient:_____
Birth Date: _____ Phone Number: _____
Address: _____
Gender of Patient: **O** Male **O** Female **O** Non-Binary **O** Choose not to say

If the patient is a minor or conserved, please list the below information:

Name of Consenting Adult: _____
Address: _____
Phone Number:_____ Relationship: _____

It is NAMHS' Policy to get consent from both parents/guardians in the event of divorce/ separation unless a court order is provided that specifies one parent has full authority over healthcare decisions. This signature and information below will be needed in such situations.

Name of Additional Consenting Adult:_____
Address: _____
Phone Number:_____ Relationship: _____

Consent for Treatment:

I, [patient name]_____, hereby consent to receive behavioral health services from NAMHS. I understand that these services may include individual therapy, group therapy, medication management, and other services as deemed necessary by my behavioral health provider.

I also understand that I have the right to refuse any service at any time. I have the right to ask questions about my treatment plan and to be informed of all risks and benefits involved in any treatment. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition.

I certify that I have the authority to consent to treatment on behalf of the patient named above. I understand that this authorization will remain in effect for one year from the date it was signed.

I have read and understood this form and give my consent to North American Mental Health Services to treat.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

NORTH AMERICAN MENTAL HEALTH SERVICES

THERAPY DISCLOSURE STATEMENT & AGREEMENT

Therapist Availability and Emergencies
You may leave a message at any time on our office's confidential voicemail. If you would like to call you back, please leave your name, phone number, and a brief message about why you are calling. Non-urgent phone calls will be returned within 24 hours during normal business hours (Monday through Friday). If you have a medical emergency or are in danger of hurting yourself or others, please call 911 or 988.

About Therapy
The goal of therapy is to help you reach your mental health goals. Your therapist will work with you to develop a treatment plan based on your specific needs and situation. Therapy is a collaborative process, and you have the right to agree or disagree with any recommendations. Your therapist will also give you regular feedback on your progress and involve you in the decision-making process.

The length of therapy and the results you can expect will vary depending on the nature of your problems and how well you respond to treatment.

Confidentiality
Your therapist is required by law to keep your protected health information (PHI) confidential. PHI is any information that can be used to identify you and that relates to your physical or mental health, such as your diagnosis, treatment, and prognosis. Your therapist may only disclose your PHI without your written consent in limited circumstances, such as:

- To provide treatment, payment, or healthcare operations
- To comply with a court order or other legal requirement
- To prevent or reduce a serious and imminent threat to your health or safety or the health or safety of another person

You have the right to request a copy of your PHI at any time. You also have the right to request that your PHI be corrected or amended.

Minors and Confidentiality
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercise of appropriate professional judgment, your therapist may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with the clinician.

No Secrets Policy
When you participate in family or couples therapy, we use a "no secrets" policy. This means that information obtained in an individual session with your therapist may be shared with other members of your family in a joint session. Your therapist will remind you of this policy before your individual session begins.

NORTH AMERICAN MENTAL HEALTH SERVICES

THERAPY DISCLOSURE STATEMENT & AGREEMENT

You also have the right to ask your therapist not to share certain information with other members of your family. Your therapist will respect your wishes, but they may also recommend that you reconsider your request, as sharing information can be beneficial to the therapy process. **If you have any questions or concerns about the "no secrets" policy, please discuss them with your therapist.**

Fees and Insurance

A NAMHS representative will discuss fees and insurance billing policies with you before you begin therapy. You are responsible for paying for any services that are not covered by your insurance.

Termination of Therapy

The length of your therapy and the timing of the eventual termination of your treatment will depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. You may discontinue therapy at any time. If you or your therapist determine that you are not benefiting from treatment, either may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Agreement

Your signature below indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Patient copy provided.

This agreement is governed by the laws of the State of California. If any provision of this agreement is held to be invalid or unenforceable, such provision shall be struck from this agreement and the remaining provisions shall remain in full force and effect.

By signing this agreement, you also agree to the following:

- You will be honest and open with your therapist about your thoughts, feelings, and experiences.
- You will be respectful of your therapist and their time.
- You will make an effort to complete any homework assignments or other tasks that your therapist recommends.
- You understand that therapy is a process and that there is no guarantee of a specific outcome. You also understand that therapy may be challenging at times, but that it is worth the effort.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

Guardian/Legal Representative Name (please print):_____ **Date:** _____

Guardian/Legal Representative Signature:_____

NORTH AMERICAN MENTAL HEALTH SERVICES

TELEHEALTH INFORMED CONSENT

This informed consent form is to provide you with information about telehealth services and to obtain your consent to receive these services. Telehealth is the delivery of healthcare services through telecommunications technology, such as video conferencing or phone calls.

Benefits and Risks of Telehealth

Telehealth can offer many benefits, including:

- **Convenience:** Telehealth allows you to receive care from your home or another convenient location.
- **Access to care:** Telehealth can help you access care from specialists who may not be available in your area.
- **Cost savings:** Telehealth can be less expensive than traditional in-person care.

However, telehealth is not without risks. Some of the potential risks of telehealth include:

- **Technical difficulties:** Telehealth appointments can be interrupted by technical problems, such as poor internet connection or audio quality.
- **Privacy concerns:** It is important to make sure that your telehealth provider uses secure technology to protect your privacy.
- **Lack of physical exam:** Telehealth providers may not be able to perform a physical exam, which may limit their ability to diagnose or treat certain conditions.

Rights and Responsibilities

As a patient, you have the right to:

- Choose whether or not to receive telehealth services.
- Ask your provider questions about telehealth and the risks and benefits involved.
- End the telehealth appointment at any time.
- Request a copy of your medical records.
- File a complaint if you believe your privacy has been violated.

You also have the responsibility to:

- Provide your provider with accurate and complete information about your medical history and symptoms.
- Follow your provider's instructions for using telehealth technology.
- Keep your telehealth appointment confidential.

Your provider has the responsibility to:

- Provide you with information about telehealth and the risks and benefits involved.
- Obtain your consent before providing telehealth services.
- Protect your privacy and the confidentiality of your medical information.
- Provide you with high-quality care that meets the same standards as in-person care

NORTH AMERICAN MENTAL HEALTH SERVICES

TELEHEALTH INFORMED CONSENT

As a minor, you have the right to:
- Ask questions about telehealth and the risks and benefits involved.
- Refuse to participate in the telehealth appointment at any time.
- Ask for a parent or guardian to be present during the telehealth appointment.

You also have the responsibility to:
- Provide your provider with accurate and complete information about your medical history and symptoms.
- Be honest and open with your provider.

If you are a minor, your parent or guardian must sign this consent form on your behalf. If you are between the ages of 14 and 18, you may also need to sign this consent form

Your parent or guardian also has the right to:
- Choose whether or not you receive telehealth services.
- Ask your provider questions about telehealth and the risks and benefits involved.
- End the telehealth appointment at any time.
- Request a copy of your medical records.
- File a complaint if they believe your privacy has been violated.

Your parent or guardian also has the responsibility to:
- Supervise you during the telehealth appointment.
- Keep your telehealth appointment confidential.

Additional Information
- Telehealth services can only be provided to patients who are residing in the state of California at the time of service.
- Telehealth services are not a substitute for all in-person care. Your provider may recommend that you receive in-person care for certain conditions.
- You may be asked to sign a separate agreement for telehealth services.

Consent

I have read and understood this informed consent form. I agree to receive telehealth services from North American Mental Health Services. I understand that I have the right to end the telehealth appointment at any time.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

Guardian/Legal Representative Name (please print):_____ **Date:** _____

Guardian/Legal Representative Signature:_____

NORTH AMERICAN MENTAL HEALTH SERVICES

NEW PATIENT FINANCIAL CONSENT

I agree to the following financial terms and conditions for my care at North American Mental Health Services (NAMHS):

- I will be responsible for all charges incurred for my care, regardless of whether or not my insurance pays for them.
- I understand that NAMHS is contracted with various health insurance plans, including but not limited to Medicaid, and various commercial insurance plans. If my insurance plan is contracted with NAMHS, NAMHS will file a claim on my behalf for the services I receive. If my health insurance is not contracted with NAMHS, NAMHS will do its best to bill my insurance based on the information I provide them, as a courtesy. I will be responsible to pay any amount up to the whole charge that my insurance does not cover.
- I understand that I am liable for any out-of-pocket expenses including but not limited to deductibles, co-insurances, co-pay's and/or services not covered by my insurance plan. Some insurance plans also require a prior authorization for a referral. NAMHS will help obtain a prior authorization for referral, however I am responsible to ensure the required authorization is provided in advance.
- In some instances, NAMHS cannot bill my insurance carrier. This includes cases involving auto accidents or insurance liens. However, NAMHS can provide all of the information necessary to submit a claim to my insurance should one of these instances apply.
- It is my responsibility to ensure that all services rendered by NAMHS on my behalf are paid in full within thirty (30) days of the statement date. Please note that, with the exception of errors, NAMHS does not change the reason for my services (billing codes) once they have been submitted to my insurance company.
- I understand that I am ultimately responsible for the payment of the medical bill. If it becomes necessary for NAMHS to collect payment, I understand that I will be responsible for legal costs, including attorney's fees.
- I consent that payments from authorized Medicare, Medicaid, Government and any other insurance or third-party benefits can be made on my behalf, and/or on behalf of all members covered under my insurance plan, directly to NAMHS for services provided.
- I understand that if any fees are due for labs, whether collected at NAMHS or at a lab collection site, it is the financial responsibility of the patient. I understand that I will be responsible for providing my insurance information to the Lab if I wish them to bill my insurance.

I have read and understand this informed consent form. I agree to receive services from NAMHS under the terms and conditions outlined above.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

Guardian/Legal Representative Name (please print):_____ **Date:** _____

Guardian/Legal Representative Signature:_____

NORTH AMERICAN MENTAL HEALTH SERVICES

PATIENT INFORMATION FORM

Please complete all information fully (please print)

Last name: _____ First name:_____ Middle initial: _____
Date of birth:_____ Age:_____ SSN:_____ Ethnicity:_____
Pronoun: He/Him She/Her They/Them/Their Other _____
Gender Identity: Male Female Non Binary Other _____
Sex Assigned at Birth: Male Female N/A
Marital Status: Married Single Divorced Widowed
Employment Status:
Employed full time Employed part time Unemployed Retired Student
Spoken Language:_____ Is a translator required: Yes No

If a minor:

Does the child live with: Mom Dad Guardian Other _____
If minor lives with only one parent, who has legal custody? Mom Dad
Is there court documents to support this? Yes No
Does the patient have any cultural needs?_____

Contact Information

Home Address: _____
City: _____ State:_____ Zip code: _____

Mailing Address:_____
City: _____ State:_____ Zip code: _____

Primary Phone Number: _____ Secondary Phone Number: _____
Email address: _____

Emergency contact name: _____ Phone Number: _____
Relationship to Patient:_____

By checking this box you are allowing North American Mental Health Services to contact the above person in the case of an emergency. Personal health information will only be provided on an emergency basis. This does not allow this person to contact our office and ask about personal mental health information about you. If you would like anybody to have information about you please ask for a Release of Information form.

NORTH AMERICAN MENTAL HEALTH SERVICES

PATIENT INFORMATION FORM

Guarantor Information (Person responsible for payment):

Last name: _____ First name:_____ Middle initial: _____

Primary Phone number: _____ Spoken Language:_____

Relationship to patient: Self Spouse Parent Legal Guardian/Conservator

Insurance information:

Insurance company: _____ Subscriber Name: _____

Subscriber ID: _____ Group number: _____

Subscriber DOB:_____ Subscriber SSN: _____

Secondary Insurance information:

Insurance company: _____ Subscriber Name: _____

Subscriber ID: _____ Group number: _____

Subscriber DOB:_____ Subscriber SSN: _____

Do you receive services through a Regional Center? Yes No

Were you referred? Yes No

If yes, than by whom?_____

Additional information:

- If you have any questions or concerns, please do not hesitate to ask. We are here to help you in any way we can.
- We respect your privacy and will keep your information confidential.
- We look forward to working with you to improve your mental health and well-being.

Thank you for choosing North American Mental Health Services!

CONTROLLED SUBSTANCE & PRESCRIPTION REFILL AGREEMENTS

Controlled substance medications (i.e., benzodiazepines, sedatives, stimulants, etc.) are very useful, but have potential for misuse; therefore, they are controlled by local, state, and federal government. They are intended to improve function and/or ability to work, not simply to feel good.

I understand and voluntarily agree that:

- There is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.
- I will inform my provider of any current or past substance abuse, or any current or past substance abuse of any immediate family member.
- I will not request or accept controlled substance medication from any other physician or individual while being prescribed such medication from Native American Mental Health Services or North American Mental Health Services (NAMHS) provider(s). Besides being illegal to do so, it may endanger my health. The only exception is upon admittance to a hospital.
- I agree to use one pharmacy for my medications. I will tell the provider all medications that I may take. I will supply prescriptions in original bottles if requested by the provider. I will also inform the provider of any new medical conditions, new medications, and of any adverse effects I may experience from any of the medications I take or have taken in the past.
- I will inform my other health care providers that I am obtaining controlled medications from my provider at NAMHS.
- I understand I am responsible for my controlled medications. It is my responsibility to monitor the amount remaining in my prescription. It is my responsibility to keep my medications away from children.
- I understand that if my medication is lost, stolen, misplaced, or used sooner than prescribed my provider may not refill or replace the medication. If my medication is stolen, I will need to provide a copy of the filed police report to my provider. I will not allow anyone else to have, use, sell, or in any way have access to these medications. Sharing medications with anyone is against the law.
- I understand the importance of following my treatment plan as directed by my provider.
- I will cooperate with unannounced urine or blood toxicology screenings, as well as any random pill counts of medication if requested by my provider. Failure to comply will be considered a positive toxicology result.
- I understand that the presence of unauthorized and/or illegal substances in the toxicology screenings may result in treatment being stopped and possibly being discharged as a patient.
- I understand that I will take my medication as instructed and prescribed, and I will not exceed the maximum dosage prescribed. Any change in dosage must be approved by my provider.
- I understand that tampering with a written prescription is a felony, and I will not change or tamper with my providers' written prescription. I am also aware that attempting to obtain a controlled substance under false pretenses is illegal.

CONTROLLED SUBSTANCE & PRESCRIPTION REFILL AGREEMENTS

This policy is in place to ensure that patients have their medications refilled in a timely manner and that NAMHS has adequate time to process the refill requests. In order to get prescription refills sent to the pharmacy in a timely manner we ask that you do the following:

- Call your pharmacy and have them fax a refill request to NAMHS.
- This needs to be done **ONE WEEK PRIOR TO WHEN YOU ARE DUE FOR A REFILL**. This does not include controlled substances. In order to get a controlled substance prescription refilled you must do the following:
- Call our clinic and notify the staff of your request **ONE WEEK PRIOR TO WHEN YOU ARE DUE FOR A REFILL.**
- You are responsible for making sure that you give the pharmacy staff and NAMHS staff enough time in advance to get the refill approved and filled before you run out of your medication. Without 1 week notice we cannot guarantee your prescription can be filled before you run out.
- As a courtesy to NAMHS staff and to make the process go faster we ask that you choose one pharmacy for all your medications.
- Patient needs to be compliant with treatment plans to be eligible for refills.

PLEASE SIGN BELOW STATING YOU UNDERSTAND, AND YOU WILL COMPLY WITH THE CONTROLLED SUBSTANCE AGREEMENT, AS WELL AS THE PRESCRIPTION REFILL POLICY.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

Guardian/Legal Representative Name (please print):_____ **Date:** _____

Guardian/Legal Representative Signature:_____

NAMHS NO-SHOW, LATE & CANCELLATION POLICY

Description:
"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives 5 minutes (medication management) and 10 minutes (therapy) after the expected appointment time.

Policy
It is the policy of NAMHS to monitor and manage appointment no-shows, late cancellations, and cancelation of consecutive appointments. North American Mental Health Services' goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows NAMHS to better utilize appointments for other patients in need of prompt medical care. The management of no-shows and cancellations is managed separately for medication management and therapy services.

1. In the event a patient does not show/attend scheduled appointment it will qualify as one "no show" appointment.
2. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time.
3. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available.
   - Arrives more than 5 minutes late for a Medication Management appointment.
   - Arrives more than 10 minutes late for a Therapy appointment.
4. Cancelation of 2 or more consecutive appointments will qualify as one "no show" appointment.
5. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations" within a 90-day period, the patient may be subject to discharge from North American Mental Health Services upon the clinical decision of their provider. If a patient is discharged from their clinician's caseload and wishes to later re-establish care, they will need to schedule through NAMHS' in-take process.

I have read and understand this No-show, Late, & Cancellation policy. I agree to receive services from NAMHS under the terms and conditions outlined above.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

Guardian/Legal Representative Name (please print):_____ **Date:** _____

Guardian/Legal Representative Signature:_____

NORTH AMERICAN MENTAL HEALTH SERVICES

MENTAL HEALTH QUESTIONNAIRE

Please answer the following questions to the best of your ability. Your responses will help us to better understand your mental health and needs.

Mental Health Symptoms

Have you experienced any of the following symptoms in the past two weeks?
(Please check all that apply)

- Anger
- Sedated feeling
- Drug/alcohol dependency
- Sad
- Flashbacks
- Overwhelmed
- Trauma
- Euphoric
- Appetite change
- Fatigue
- Compulsive
- Mood changes
- Worry
- Hopeless
- Poor concentration
- Poor job/school performance
- Sense of superiority
- Unable to focus
- Hallucinations
- Self-harm
- Isolating
- Distracted easily
- Lack of interest in activities
- Thoughts of death or suicide

Please list any other symptoms you are having that are not listed: _____

_____

Thoughts

Scattered Racing Negative Suicidal Obsessive

Substance Use

Do you use any alcohol or drugs? Yes No
If so, what substances do you use and how often?_____

Have you ever experienced problems with alcohol or drugs? Yes No
If so, what problems?_____

_____

Treatment

Are you currently seeing a therapist or counselor? Yes No
Are you currently being treated by a psychiatric provider? Yes No
Are you currently in any substance use treatment programs? Yes No

NORTH AMERICAN MENTAL HEALTH SERVICES

MENTAL HEALTH QUESTIONNAIRE

Medical history

Do you have any of the following medical issues (check all the apply)?

- High blood pressure
- Diabetes
- Stroke
- Head injury
- Dementia
- Kidney disease
- Liver disease
- Heart disease
- Lung disease
- Glaucoma
- Parkinson's disease
- Visual impairments
- Hearing impairment
- Other: _____

Current medications

List all medications you are taking regularly. Include all prescription and non-prescription medications.

Medication Name	Dosage	Frequency

Are you allergic to any medications? Yes No

If yes, Please list_____

Preferred Pharmacy:_____

If you have any questions or concerns, please do not hesitate to ask a NAMHS representative.

NORTH AMERICAN MENTAL HEALTH SERVICES

MENTAL HEALTH PATIENT'S RIGHTS

YOU HAVE THE RIGHT:

- To dignity, privacy and humane care
- To be free from harm including unnecessary or excessive physical restraint, medication, isolation, abuse and neglect
- To receive information about your treatment and to participate in planning your treatment
- To consent or refuse to consent to treatment, unless there is a legally-defined emergency or a legal determination of incapacity
- To client-centered services designed to meet your individual goals, diverse needs, concerns, strengths, motivations and disabilities
- To treatment services which increase your ability to be more independent
- To prompt medical care and treatment
- To services and information in a language you can understand and that is sensitive to cultural diversity and special needs
- To keep and use your own personal possessions including toilet articles
- To have access to individual storage space for your private use
- To keep and spend a reasonable sum of your own money for small purchases
- To have reasonable access to telephones—both to make and to receive confidential calls or have such calls made for you
- To have access to letter-writing material and stamps to mail and to receive unopened correspondence
- To social interaction, participation in community activities, physical exercise and recreational opportunities
- To see visitors every day
- To wear your own clothes
- To see and receive the services of a patient-advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services
- To religious freedom and practice
- To participate in appropriate programs of publicly supported education
- To be free from hazardous procedures
- And all other rights as provided by law or regulation

Mental health patients have the same legal rights guaranteed to everyone by the Constitution and laws of the United States and California.

NOTICE OF PRIVACY

This notice describes how we may use and disclose your protected health information (PHI) and your rights regarding your PHI.

What is protected health information?
PHI is any information about you, including demographic information, which may identify you and that relates to your past, present, or future physical or mental health condition, the provision of health care to you, or the payment for your health care.

How we may use and disclose your PHI

We may use and disclose your PHI for the following purposes:
- To provide you with treatment, payment, and health care operations.
- To coordinate your care with other health care providers.
- To obtain payment for services provided to you.
- For public health activities such as reporting communicable diseases to the California Department of Public Health.
- For research activities, but only after we have obtained your written authorization.
- For other purposes as permitted or required by law.

Your rights regarding your PHI

You have the following rights regarding your PHI:
- The right to request a copy of your PHI.
- The right to request a restriction on how we use or disclose your PHI.
- The right to request a correction to your PHI.
- The right to request an accounting of how we have used and disclosed your PHI in the past six years.
- The right to file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

In addition to the rights listed above, California patients have the following rights:
- The right to know the specific purposes for which your PHI will be used or disclosed.
- The right to opt out of the sale of your PHI.
- The right to request a copy of your PHI in an electronic format.
- The right to access your PHI through a third-party app.

NOTICE OF PRIVACY

How to contact us
If you have any questions about this notice or your privacy rights, please contact our Privacy Officer at:

North American Mental Health Services
2165 Larkspur Ln
Redding, California 96002
Phone: 530-232-5770
Fax: 530-338-3356
Email: compliance@namhs.com

How to file a complaint
If you believe your privacy rights have been violated, you may file a complaint with us or with the California Attorney General's Office.

To file a complaint with us, please contact our Privacy Officer at the contact information listed above.

To file a complaint with the California Attorney General's Office, please visit their website at https://oag.ca.gov/.

- We cannot, and will not, require you to waive the right to file a complaint with the California Attorney General's Office as a condition of receiving treatment from NAMHS.
- We cannot, and will not, retaliate against you for filing a complaint with the California Attorney General's Office

Effective date
This notice is effective as of 10/01/2023. We reserve the right to change this notice at any time. If we make any changes, we will provide you with a revised notice.

I have read and understand this Notice of Privacy regarding my protected health information and general privacy.

Patient Name (please print):_____ **Date:** _____

Patient Signature:_____

Guardian/Legal Representative Name (please print):_____ **Date:** _____

Guardian/Legal Representative Signature:_____