Intake Paperwork Instructions:

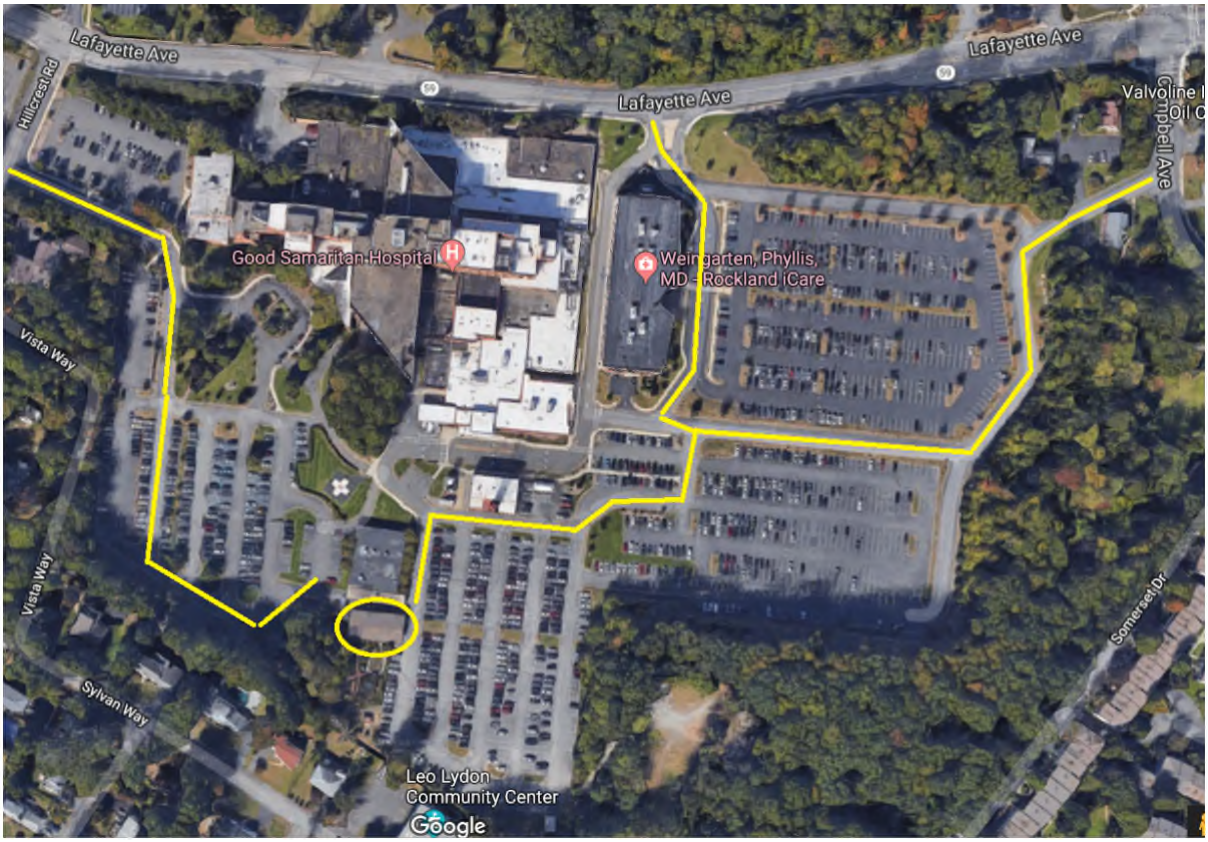
This is a PDF form that you can type directly on. Once completed please send back to: Frawley-OC@bshsi.org

Intake paperwork must be received and completed 24 hours before your scheduled appointment.

Virtual Session Instructions and links are attached to this packet. The platform we use is DOXY.ME. (See providers links below)

If you have questions or comments, please contact us at 845-368-5222, option 3.

Campus Map with Sheehan Building Location:



Dear Friend;

We want to welcome you and thank you for choosing the Frawley Mental Health Clinic. It is our mission to provide you with the best clinical practices to serve you and your family in the treatment of your mental health needs. Your physical health is also as important to us as your mental health. We can assist in providing in-house or community referrals for primary health care physicians. Providing a holistic approach has been correlated to reducing unnecessary hospitalizations. We believe in collaboration, confidentiality, your right to self–determination but most importantly we believe in you. We demonstrate this belief by creating individualized treatment plans that gets revisited and revised every three months. Our clinical staff at Frawley utilizes an array of evidenced based treatment tailored to our person-centered approach. This is evident by the culturally sensitive and gender inclusive services we provide.

Please complete the attached paperwork for your intake appointment. If you have any questions regarding the paperwork please ask staff for assistance. Please do your best to answer all the assessment tools in the packet before you meet with the clinician.

Thank you for choosing Frawley Clinic as your provider. We look forward to providing the utmost care for you and your family.

Warmly;

Frawley Outpatient Team

(845)368-5222

Located in the Sheehan Building

VIRTUAL SESSION INSTRUCTIONS:

Platform Name: DOXY.ME

Search Engine to use: Google Chrome works much better than internet explorer

Link: https://doxy.me/ (Main Website)

Trouble Shooting Link: https://help.doxy.me/en/

At the time of your appointment please click the link below:

Dr. Kushnir: https://doxy.me/drkushnirfrawley

Jenna McKean: https://doxy.me/jennamckeanfrawley

Dr Cooper https://doxy.me/frawleystevenjay

Jessica Bass https://doxy.me/integrativetherapistjess

Robyn Smith https://doxy.me/frawleyrobynsmith

Natalie Diaz https://doxy.me/frawleynataliediaz

Dr. Longe https://doxy.me/drabilonge

Susan Hart https://doxy.me/frawleysusanhart

Sheila Magee https://doxy.me/frawleysheila

Samantha Olson https://doxy.me/samanthafrawleytherapist

Nikki Schultz https://doxy.me/integrativetherapistnikki

Name:	Birthdate:	Date:
SS #:	SS # of Parent: *(if applicable)*	Referral Source:
Gender Identity:	Sex Assigned at Birth:	Marital Status:
Sexual Orientation:		
Address:		
City:	State:	
Religion:	Ethnic Group(s):	
Email:	Military Status:	
Phone (Home):	Emergency Contact Name:	
Phone (Work):	Emergency Contact Number:	
Phone (Cell):	Relationship to Client:	
Employed: ☐ Yes ☐ No ☐ Other:	Do you have any children? ☐ Yes ☐ No	
Employer:	What are their ages?	
Address:		

Do you have a Healthcare Proxy/Advanced Directive? ☐ Yes ☐ No
If not, would you like information on how to create one? ☐ Yes ☐ No
Have you been hospitalized for Psychiatric or Substance Abuse treatment: ☐ Yes ☐ No
If so, Please give the dates and locations:
Brief statement of problem for which you are seeking help:
Medicaid #: Medicare #:
Is Medicare due to: ☐ Age ☐ Disability ☐ End Stage Renal Disease

HEALTH SCREENING

PATIENT'S NAME: _____
D.O.B: _____ SEX: _____ DATE COMPLETED: _____

ACCESS TO FIREARMS: ☐ YES ☐ NO

CURRENT OR PAST HISTORY OF THE FOLLOWING: Mark with an "X"

Please Check All That Applies:	Self	Family	Please specify which family member
ABNORMAL MUSCULAR MOVEMENT			
ALLERGY			
APPETITE CHANGES			
ASTHMA			
BLOOD DISORDER (e.g., Anemia)			
BONE OR JOINT PROBLEM			
CAFFEINATED BEVERAGES (E.G., Coffee, Cola)			
CANCER			
CONCENTRATION/MEMORY DIFFICULTIES			
DIABETES			
EATING DISORDER			
EAR, NOSE, AND THROAT DISORDER			
ENDOCRINE DISORDER (e.g., Thyroid)			
EXERCISE (Currently)			
ENERGY CHANGES			
EYE DISEASE (e.g., Glaucoma)			
GYNECOLOGICAL PROBLEM			
HEARING DISORDER			
HEADACHES			
HEAD INJURY (e.g., Loss of Consciousness)			
HEART AND/OR CIRCULATORY PROBLEM			
HIGH OR LOW BLOOD PRESSURE			
IMMUNIZATIONS			
HIGH OR LOW BLOOD SUGAR			
LIVER DISEASE (e.g., Hepatitis)			
LUNG DISEASE			
LYME DISEASE			
NIGHTMARES			
PREGNANCY			
PHYSICAL LIMITATION			
SEIZURE DISORDER (e.g., Epilepsy)			
SEXUAL FUNCTIONING PROBLEMS			
SEXUALLY TRANSMITTED DISEASE (e.g., Syphilis)			
SLEEP DIFFICULTIES			
SMOKING OR TOBACCO USE			
STOMACH OR BOWEL PROBLEMS			
UNUSUAL THIRST			
TICS (Verbal or Motor)			
URINARY DISEASE (e.g., Kidney, Bladder)			
DRUG OR ALCOHOL USE			
DRUG/ALCOHOL TREATMENT, REHAB, DETOX			
PSYCHIATRIC PROBLEMS			
PSYCHIATRIC TREATMENT/HOSPITALIZATIONS			
SUICIDE ATTEMPTS			
HOSPITALIZATIONS (MEDICAL/SURGICAL)			

SIGNIFICANT MEDICAL PROBLEMS			
LEARNING DISABILITIES/SCHOOL PROBLEMS			
WEIGHT:	**HEIGHT:**		

HAVE YOU HAD A PHYSICAL EXAM IN THE LAST YEAR? ☐ Yes ☐ No DATE OF LAST VISIT: _____

REASON FOR EXAM: _____

NAME OF YOUR DOCTOR: _____ PHONE: _____

ADDRESS: _____

PHARMACY: _____

CURRENT MEDICATIONS: (Prescription and Over-the-Counter)

Name and Purpose	Dose/Frequency	Date Started

PAST MEDICATIONS: (Prescription and Over-the-Counter)

Name and Purpose	Dose/Frequency	Date of Use

COMPLETED BY _____ REVIEWED BY _____

Patient's Signature Intake Clinician Date

Please type to confirm agreement*

ASSESSMENT AND RECOMMENDATIONS BY MEDICAL PROFESSIONAL, BASED ON REVIEW OF HEALTH SCREEN

_____ No apparent medical problem. Physical assessment recommended on as needed basis.

_____ Currently receiving medical care and follow up at private MD/Clinic

Copies of medical reports needed YES ____ NO ____

_____ Needs medical care and follow up. Refer to _____

COMMENTS:

_____ _____

Medical Professional Signature **Date**

MONSIGNOR PATRICK J. FRAWLEY MENTAL HEALTH CLINIC

Insurance Information

NAME: _____ SS #: _____

PRIMARY INSURANCE COMPANY: _____

IDENTIFICATION #: _____ GROUP #:_____

PRIMARY POLICY HOLDER: _____

DATE OF BIRTH: _____ SS #: _____

RELATIONSHIP TO PATIENT: _____ AUTH #: _____

EMPLOYER NAME & ADDRESS: _____

_____

SECONDARY INSURANCE: _____

IDENTIFICATION #: _____ GROUP #:_____

PRIMARY POLICY HOLDER: _____

DATE OF BIRTH: _____ SS #: _____

RELATIONSHIP TO PATIENT: _____ AUTH #: _____

EMPLOYER NAME & ADDRESS: _____

_____

ASSIGNMENT: (PRINT NAME AND SIGN ON THE LAST LINE)

I, _____, AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS CLAIMS SUBMITTED BY GOOD SAMARITAN HOSPITAL

I, _____, AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO GOOD SAMARITAN HOSPITAL FOR SERVICES PROVIDED BY THE OUTPATIENT MENTAL HEALTH CLINIC.

WHEN REQUIRED IT IS THE RESPONSIBILTY OF THE PATIENT/RESPONSIBLE PARTY TO GET ANY NEEDED REFERRALS AND PREAUTHORIZATIONS PRIOR TO THE FIRST VISIT. THE PATIENT/RESPONSIBLE PARTY IS ALSO HELD RESPONSIBLE FOR ANY COYPAYMENTS AND/OR DEDUCTIBLE AMOUNTS

I, _____, HAVE READ AND UNDERSTAND THE ABOVE.

SIGNATURE: _____ DATE: _____

MONSIGNOR PATRICK J. FRAWLEY MENTAL HEALTH CLINIC
Acknowledgement Disclaimers

ACKNOWLEDGEMENT OF FEES AND PRACTICES

I have read the statement regarding changes in fee payment procedure and understand that I will not be able to attend my session with either my MD or therapist if payment is not made prior to my appointment. I understand that to make alternate plans or exception to this procedure, I must discuss this with my therapist, office manager or clinical director for approval or further assistance.

Name: _____

Signature: _____

Date: _____ _____

……

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may receive separate authorizations for special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information and mental health information.

_____

Signature of Patient or Personal Representative

_____ Date: _____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

……

I have received, read and understand the Monsignor Patrick J. Frawley Welcome Letter.

Name: _____

Signature: _____

Date: _____

Welcome to the Monsignor Patrick J. Frawley Mental Health Clinic!

We are glad that you have chosen our service and look forward to our mutual participation and cooperation in the therapy process. There are certain obligations, which each of us have. We have outlined these expectations below for your reference.

General: Access to treatment is free of discrimination and treatment shall, at all times, recognize and respect the personal dignity of the client. Treatment will be planned in a collaborative process between you and your therapist to meet your individual needs. The individual sessions are generally 45 minutes in length and you and your therapist will determine the frequency of your visits during treatment planning. Of course, if you need a change, the treatment plan will reflect those changes.

Attendance: Your recovery will be greatly enhanced by consistent and strong engagement in the therapeutic process. You will demonstrate your commitment to your recovery through regular attendance and active participation in your treatment. Therefore, we expect you to place the highest importance on attending therapy sessions, as this time has been especially reserved for you. When you do not come in as scheduled, it deprives others of this time. Therefore, we ask for your cooperation in letting us know at least 24 hours in advance when possible of any appointment you will be unable to attend. If you cancel or fail to show frequently, your therapist may reevaluate your treatment plan with you and see you only on an as needed basis vs. regularly scheduled appointments. Because doctor time is limited, we may discontinue scheduling appointments if they are chronically missed. If you have any questions about this, please discuss with therapist or the Director of the clinic.

Problems/Grievances: Therapy is a relationship and sometimes problems may develop between you and your therapist. There is a process to deal with resolving any issues, which may occur. The first step is to let your therapist know how you are feeling. Often these issues are a normal part of the therapy process and bringing your feelings to your therapist is important to your progress. However, if you and your therapist cannot resolve the issue or complaint you can speak to the Director of Behavioral Health Services. If this issue is not resolved there is a Patient/Consumer Advocate that the Director can assist you in contacting. If this last step does not meet your needs, you can contact the N.Y.S. Office of Mental Health or the Mental Health Association for further assistance. These agencies are listed in the Patient's Bill of Rights' booklet given to you at intake, or the director can assist you as well. Complaints/ grievances will not cause termination of care nor will there be any reprisals; it is your right to initiate that process.

Fees and Payment: The clinic is a non-profit service supported by a combination of hospital, state, local and patient fees, along with third party reimbursement including Blue Cross, Medicare, Medicaid, and other commercial insurance carriers. We will be requiring you to pay your self-pay fee/co-payment and/or co-insurance prior to your session with either your therapist or physician. Patient fees are essential to the continuing delivery of our services. Clients with insurance will be responsible to pay the co-payment toward the clinic full charge. Your insurance company frequently sets this co-pay. If you have a managed care or HMO policy, you will be asked to pre-authorize your treatment here through your insurance company. Failure to do so will result in your HMO's refusal to reimburse the hospital for your services and you will be charged the full fee. Our fee negotiator can assist you with this if you run into difficulties. If you are uninsured, our Billing Department, 1 855-346-2090 option 2 will assist you to set a self-pay rate, which is a sliding scale and based upon your "family net income." Every patient is expected to pay either his or her co-payment or self-pay fee at the time services are rendered.

Prior to your Session: If you have not discussed your fee with the Billing Department, please do so as soon as possible. If your financial or insurance status should change, your fee may be adjusted accordingly. If you have any questions or concerns about your fee, please discuss with your therapist. The therapist is your principal contact and can answer any question you may have. If you are unable to pay and have been denied by Medicaid, please discuss the option of charity care with our fee negotiator. Again, thank you for choosing Frawley Outpatient as your modality of care.

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE TELEPHONE CONSENT IF GRANTED BY (if required):

Patient or Legal Authorized Representative **Telephone Consent if Granted by: "if required"**

Patient Print Name/Signature:_____ Name of Legal Guardian:_____

Legal Author/
Representative:_____ Signature of Caller:_____

Patient unable/refused to Sign: _____

MEDICARE PATIENTS ONLY -LIFETIME RESERVE DAYS:

In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days.

Patient Print Name/Signature: _____ Date:

Name: _____ ***Date:*** _____

Patient Health Questionnaire (PHQ–9)

1. Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Total Score: _____

2. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

NIDA-Modified ASSIST—Prescreen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has ever used cocaine in their lifetime, put a mark in the "Yes" column in the "cocaine" row.

Prescreen Question: **In your lifetime, which of the following substances have you ever used?** ***For prescription medications, please report nonmedical use only.***	**No**	**Yes**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)		
b. Alcoholic beverages (beer, wine, liquor, etc.)		
c. Cannabis (marijuana, pot, grass, hash, etc.)		
d. Cocaine (coke, crack, etc.)		
e. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
f. Methamphetamine (speed, crystal meth, ice, etc.)		
g. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
h. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
i. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
j. Street opioids (heroin, opium, etc.)		
k. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
l. Other – specify:		

- If the patient says **"NO"** for all drugs in Prescreen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to any of the drugs, ask **Question 1** of the NIDA Modified ASSIST tool.

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[1] This screening tool was adapted from the WHO Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) Version 3.0 developed and published by the World Health Organization (WHO) (available at: http://www.who.int/substance_abuse/activities/assist_v3_english.pdf)

Question 1 of the NIDA-Modified ASSIST V1.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient (circle number in appropriate row/column). To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

1. **In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?**	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. **Tobacco products (cigarettes, chewing tobacco, cigars, etc.)**	0	2	3	4	6
b. **Alcoholic beverages (beer, wine, liquor, etc.)**	0	2	3	4	6
c. **Cannabis (marijuana, pot, grass, hash, etc.)**	0	2	3	4	6
d. **Cocaine (coke, crack, etc.)**	0	2	3	4	6
e. **Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)**	0	2	3	4	6
f. **Methamphetamine (speed, crystal meth, ice, etc.)**	0	2	3	4	6
g. **Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)**	0	2	3	4	6
h. **Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)**	0	2	3	4	6
i. **Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)**	0	2	3	4	6
j. **Street opioids (heroin, opium, etc.)**	0	2	3	4	6
k. **Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)**	0	2	3	4	6
l. **Other – Specify:**	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 5-7**.
- For any recent **illicit or nonmedical prescription drug use**, go to Question 2.
- For **tobacco and alcohol**, see next page.

For Tobacco and Alcohol Use

- For patients who report use of **tobacco:** *Any* current tobacco use places a patient at risk.

  Advise *all* tobacco users to quit. For more information on smoking cessation, please see Helping Smokers Quit: A Guide for Clinicians at http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm.

- **For alcohol:** Question patient in more detail about frequency and quantity of use:

If the answer is:

☐ None: **Advise** patient to stay within these limits

For healthy men under the age of 65: No more than 4 drinks per day AND no more than 14 drinks per week.

For healthy women under the age of 65 and not pregnant (and healthy men over age 65): No more than 3 drinks per day AND no more than 7 drinks per week.

Recommend lower limits or abstinence as medically indicated; for example for patients who:

- Take medications that interact with alcohol
- Have a health condition exacerbated by alcohol
- Are pregnant (advice abstinence).

Encourage talking openly about alcohol and any concerns it may raise, re-screen annually.

Reminder:

Many people don't know what counts as a standard drink (e.g., 12 oz beer, 5 oz wine, 1.5 oz liquor).

For information, please see http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide13_p_mats.htm

☐ One or more times of heavy drinking (≥ 5 for men; ≥ 4 for women): Patient is an at-risk drinker.

Please see NIAAA website "How to help patients who drink too much: A clinical approach" at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm for additional information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders.

Questions 2-7 of the NIDA-Modified ASSIST V1.0

Instructions: Patients may fill in the following form themselves or screening personel can offer to read the questions aloud in a private setting and complete the form (circle number in appropriate row/column). To preserve confidentiality, a protective sheet should be placed on top of the questionaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

2. <u>In the past 3 months</u>, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

3. <u>During the past 3 months</u>, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

4. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 5 & 6 for all substances **ever used** (i.e., those endorsed in the Prescreen).

5. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

6. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 7 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

7. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
    - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
    - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 1-6 above. This is the Substance Involvement (SI) score. Do not include the results from either the Prescreen or Q 7 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient's risk level.

To determine patient's risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

The PDF fill-able version allows patient identifying data to be saved and stored. It allows responses to be entered and will automatically lead you to the next appropriate question and tally the scores at the end.

Adverse Childhood Experience (ACE) Questionnaire

Name: _____ Date: _____

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household <u>often</u>:

   Swear at you, insult you, put you down, or humiliate you?

   Or

   Act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No If Yes, enter 1 _____

2. Did a parent or other adult in the household <u>often</u>:

   Push, grab, slap, or throw something at you?

   Or

   Ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No If Yes, enter 1 _____

3. Did an adult or person at least 5 years older than you <u>ever</u>:

   Touch or fondle you or have you touch their body in a sexual way?

   Or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No If Yes, enter 1 _____

4. Did you <u>often</u> feel that:

   No one in your family loved you or thought you were important or special?

   Or

Adverse Childhood Experience (ACE) Questionnaire

Your family didn't look out for each other, feel close to each other, or support each other?

☐ Yes ☐ No If Yes, enter 1 _____

5. Did you often feel that:

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   Or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No If Yes, enter 1 _____

6. Were your parents ever separated or divorced?

   ☐ Yes ☐ No If Yes, enter 1 _____

7. Were any of your parents or other adult caregivers:

   Often pushed, grabbed, slapped, or had something thrown at them?

   Or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   Or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No If Yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

    ☐ Yes ☐ No If Yes, enter 1 _____

ACE SCORE (Total "Yes" Answers): _____

Adverse Childhood Experience (ACE) Questionnaire

PROVIDER INSTRUCTIONS ***(Revised April 11, 2019)***

Beginning June 1, 2019, the ACE Questionnaire shall be given to all adults ages 18 and older* who are seeking behavioral health services from the ODMHSAS and the OHCA (SoonerCare/Medicaid); with minimal exception**. The ACE score shall be reported on all CDC/PA 23 (admissions) and CDC/PA 42 (6-month updates/extensions). The questionnaire only has to be given once per person, per provider- but the score must be reported/carried forward on all subsequent CDCs like some of the other CDC responses (ex: gender and race are typically reported/carried forward on each CDC and rarely change). Valid ACE Scores should be entered on the CDC in one of the following formats: 00 to 10 or 0 to 10 (00 to 10, double digits, is preferred). For currently admitted/open adult clients, the ACE Questionnaire shall be given at the next 6-month treatment update and reported on the CDC/PA 42 (6-month update/extension).

*Note: This questionnaire should only be given to adults ages 18 and older; it should not be given to children or youth under the age of 18.

**Exceptions: Due to the nature of some levels of care and program types, there are circumstances in which the ACE Questionnaire shall not be required. They are as follows:

- *Community Living (CL) Level of Care* (ex: Homeless, Housing, Residential Care)
- *Service Focus*- 11 (Homeless, Housing, Residential Care); 23 (Day School); 24 Medication Clinic Only; and 26 Mobile Crisis.

GIVING THE ACE QUESTIONNAIRE

The ACE Questionnaire is to be given at the time of clinical assessment (at initial clinical assessment for new clients, and for currently admitted/open clients- at clinical assessment update completed as a part of the service plan update process at 6-month treatment update). This is to ensure ready access to a therapist should one be needed to address any issue that might arise from revisiting childhood trauma.

It is a self-administered instrument and shall be completed by the individual seeking services without intervention from staff (ex: staff may not reframe the question or give explanation regarding the intent of the question). The only assistance that staff may provide is with regard to literacy or vision challenges, and in that instance the introduction statement and questions must be read aloud to the individual exactly as written on the questionnaire. To ensure a trauma informed process, it is important that the introduction statement on the questionnaire is either read by the client or read to the client.

Due to the sensitive nature of the questions, the individual completing the ACE Questionnaire should be given a confidential space in which to complete it. They may choose to have someone with them in the room for support (ex: Peer Support Specialist, family, friend).

Scoring

For each of the ten (10) questions on the questionnaire, the individual will give a Yes or No answer. When scoring, each “Yes” answer will be given one (1) point. These points will be tallied to determine the individuals ACE Score.

NIDA Clinical Trials Network

Fagerstrom Test for Nicotine Dependence (FND)

Segment: _ _

Visit Number: _ _

NONE SMOKER:

Date of Assessment: (mm/dd/yyyy) _ _/_ _/_ _ _ _

Do you currently smoke cigarettes?

☐No ☐Yes

If "yes," read each question below. For each question, enter the answer choice which best describes your response.

1. **How soon after you wake up do you smoke your first cigarette?**

   ☐Within 5 minutes ☐31 to 60 minutes

   ☐6 to 30 minutes ☐After 60 minutes

2. **Do you find it difficult to refrain from smoking in places where it is forbidden** (e.g., in church, at the library, in the cinema)**?**

   ☐No ☐Yes

3. **Which cigarette would you hate most to give up?**

   ☐The first one in the morning ☐Any other

4. **How many cigarettes per day do you smoke?**

   ☐10 or less ☐21 to 30

   ☐11 to 20 ☐31 or more

5. **Do you smoke more frequently during the first hours after waking than during the rest of the day?**

   ☐No ☐Yes

6. **Do you smoke when you are so ill that you are in bed most of the day?**

   ☐No ☐Yes

Comments:

Heatherton TF, Kozlowski LT Frecker RC (1991). The Fagerström Test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire. British Journal of Addiction 86:1119-27.

NIDA Clinical Trials Network

Fagerstrom Test for Nicotine Dependence (FND)

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Your score was: (your level of dependence on nicotine is): _ _

Heatherton TF, Kozlowski LT Frecker RC (1991). The Fagerström Test for Nicotine Dependence: A revision of the Fagerström Tolerance Questionnaire. British Journal of Addiction 86:1119-27.

Screening tool is based primarily on trauma symptoms, not just on your current symptoms.

Trauma checklist (PCL-C)

(adapted from Weathers, Litz, Huska, & Keane, 1994)

Name: _____ **Date**: _____

Below is a list of problems and complaints that people sometimes have in response to traumatic and stressful life experiences. Please read each one carefully and tick the box to indicate how much you have been bothered by that problem in **the past month**.

No	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated *disturbing memories*, *thoughts, or images* of a stressful experience from the past?					
2	Repeated *disturbing dreams* of a stressful experience from the past?					
3	Suddenly *acting or feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4	Feeling *very upset* when *something reminded you* of a stressful experience from the past?					
5	Having *physical reactions* (e.g. heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6	Avoid *thinking about* or *talking about* a stressful experience from the past, or avoid *having feelings* related to it?					
7	Avoid *activities or situations* because they remind you of a stressful experience from the past?					
8	Trouble *remembering important parts* of a stressful experience from the past?					

No	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
9	Loss of *interest in things that you used to enjoy*?					
10	Feeling *distant or cut off* from other people?					
11	Feeling *emotionally numb*, or being unable to have loving feelings for those close to you?					
12	Feeling as if your *future* will somehow be cut short?					
13	Trouble *falling or staying asleep*?					
14	Feeling *irritable* or having *angry outbursts*?					
15	Having *difficulty concentrating*?					
16	Being '*super alert*' or watchful/on guard?					
17	Feeling *jumpy* or easily startled?					

(adapted from Weathers, Litz, Huska, & Keane, 1994)

Trauma/PTSD checklist (PCL-C)

The PCL-C asks about symptoms in relation to generic stressful experiences, and can be used with any population. This version simplifies assessment based on multiple traumas, because symptom endorsements are not attributed to a specific event. In many circumstances, it is advisable to also assess traumatic event exposure to ensure that a respondent has experienced at least one event that meets DSM-IV Criterion A.

Administration and Scoring

The PCL is a self-report instrument that can be read by respondents themselves, or read to them either in person or over the phone. It can be completed in approximately 5-10 minutes.

The PCL-C can be scored in several ways:

1) Treat response categories 3–5 (*Moderately* or above) as symptomatic and responses 1–2 (below *Moderately*) as non-symptomatic, then use the following DSM criteria for a diagnosis:

- Symptomatic response to at least 1 “B” item (Questions 1–5),
- Symptomatic response to at least 3 “C” items (Questions 6–12), and
- Symptomatic response to at least 2 “D” items (Questions 13–17)

2) Add up the items to create total severity score. A **Total symptom severity score** (range 17-85) can be obtained by summing the scores from each of the 17 items that have response options ranging from 1 ‘Not at all’ to 5 ‘Extremely’.

The gold standard for diagnosing PTSD is a structured clinical interview such as the clinician administered PTSD scale (CAPS). When necessary, the PCL can be scored to provide a presumptive diagnosis. This has been done in three ways:

1. Determine whether an individual meets DSM-IV symptom criteria, as defined by at least 1 criterion B item (questions 1-5), 3 criterion C items (questions 6-12) and at least 2 criterion D items (questions 13-17). Symptoms rated as ‘Moderately’ or above (responses 3 through 5 on individual items) are counted as present.
2. Determine whether the total severity score exceeds a given normative threshold (see table below).
3. Combine methods (1) and (2) to ensure that an individual meets both the symptom pattern and severity threshold.

Choosing a cut-off score

Factors to be considered when choosing a PCL cut-off score include:

- **The goal of the assessment:** A lower cut-off score is considered when screening for PTSD, or when it is desirable to maximise detection of possible cases. A higher cut-off score is considered when informing diagnosis or to minimise false positives.

- **The prevalence of PTSD in the target setting:** Generally, the lower the prevalence of PTSD in a given setting, the lower the optimal cut-off score. In settings with expected high rates of PTSD, such as specialty mental health clinics, consider a

higher cut-off score. In settings with expected low rates of PTSD such as primary care clinics, or in circumstances in which patients are reluctant to disclose mental health problems, consider a lower cut-off score.

Below are suggested cut-off score ranges based on prevalence and setting characteristics. Consider scores on the low end of the range if the goal is to screen for PTSD. Consider scores on the high end of the range if the goal is to aid in diagnosis of PTSD.

Suggested PCL cut-off scores

Estimated prevalence of PTSD	Suggested PCL cut-off score
Below 15% (Primary care)	30-35
16-39% (DVA primary care, specialised medical clinics)	36-44
Above 40% (Specialist mental health clinics)	45-50

NB: these recommendations are general and approximate, and are not intended to be used for legal or policy purposes. Research is needed to establish optimal cut-off scores for a specific population.

Measuring change

Good clinical practice often involves monitoring client progress. Evidence suggests that a 5-10 point change is reliable (i.e. not due to chance) and a 10-20 point change is clinically meaningful (Monson et al., 2008). Therefore, we recommend using 5 points as a minimum threshold for determining whether an individual has responded to treatment and 10 points as a minimum threshold for determining whether the improvement is clinically meaningful.

http://www.ptsd.va.gov/professional/pages/assessments/ptsd-checklist.asp

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of Bon Secours Charity Health System (BSCHS), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood. I understand and authorize the administration of pharmaceutical agents and medications by any one of several techniques including peripheral intravenous access (inserted into a vein in an arm or leg) and peripheral insertion of a venous catheter that then enters the central circulation (PICC line). I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at BSCHS.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct BSCHS and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND CHARITY CARE NOTICE: I hereby assign to BSCHS any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by BSCHS, whether such services are considered in-or out-of-network with respect to any third party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to BSCHS, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to BSCHS for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. I understand I will receive a separate bill from my attending physician, emergency department physician, radiologist, anesthesiologist and other consultants. (However, if treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules.) As part of BSCHS's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. BSCHS has a Charity Care Program for patients who financially qualify. Please ask for more details.

CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND EMAILS: I hereby consent to BSCHS to contact me by voice call, text message and email at the Account contact telephone number (s) and Email address (es) reflected on my account. I understand that, by giving this consent BSCHS may contact me about my

medical care, or my account, such as appointment, the results of any tests or procedures, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed.

ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE: By signing below, I acknowledge receipt of the important information about paying for your care.

TELEPSYCHIATRY: I have been given basic information regarding the use of Telepsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Telepsychiatry services, in which case evaluations will not be withheld, but will be conducted in-person by appropriate clinicians. I also understand that upon my refusal of such services I will be apprised of the alternatives to Telepsychiatry services, including any delays in service, need to travel, or risks associated with not having the services provided by Telepsychiatry. Furthermore, I am made aware that each Telepsychiatry session shall not be recorded without my consent.

I do not want to participate in Telepsychiatry:

_____ (Please print name of signature)

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the hospital and Initials understand and agree that BSCHS shall not be liable for loss or damage to any personal property.

IF ADMITTED AS AN INPATIENT: I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare", information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient) with information about how I can exercise the right explained in

these materials. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information.

CONSENT TO PRESENCE OF AN OBSERVER

☐ By checking here I CONSENT to the presence of an "Observer" during my care/treatment including during procedures and/or surgery. I understand that I am not required to sign this consent in order to receive treatment. I further understand that an Observer is someone who gains greater understanding of hospital operations and patient care by observing/shadowing clinicians in a hospital setting, is not a clinician, student, vendor, volunteer or contractor, and is prohibited from assisting with or participating in my care. I can revoke this consent at any time before or during the procedure/care.

☐ By checking here I DO NOT consent to the presence of an "Observer" during my care and treatment including during procedures and/or surgery.

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE TELEPHONE CONSENT IF GRANTED BY (if required):

Patient or Legal Authorized Representative Telephone Consent if Granted by: "if required"

Patient Print Name/Signature:_____ Name of Legal Guardian:_____

Legal Author/Representative:_____

Signature of Caller:_____

Patient unable/refused to Sign: _____

MEDICARE PATIENTS ONLY -LIFETIME RESERVE DAYS:

In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days.

Patient Print Name/Signature: _____ Date:

PSYCKES Consent Form

In this Consent Form, you can choose whether to allow your provider to obtain access to your Medicaid medical records electronically through PSYCKES. This can help coordinate all the different types of health services you have received through Medicaid and make them available electronically to this provider.

You may use this Consent Form to decide whether or not to allow this provider to see and obtain access to your electronic health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I give consent"** box below, you are saying "Yes, this provider's staff involved in my care may see and access all of my medical information through PSYCKES."

If you check the **"I deny consent"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES."

This does not mean your provider is completely barred from accessing your medical information in any way. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern. There are also exceptions to the confidentiality laws that may permit your provider to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I give consent** for this provider to access **all** of my electronic health information through PSYCKES in connection with providing me any health care services.

☐ **I deny consent** for this provider to access my electronic health information through PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient:	Date of Birth of Patient:	Patient's Medicaid ID Number:
Signature of Patient or Patient's Legal Representative:	Date:	
Print name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable):	
Signature of Witness:	Print name of Witness:	

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by **only** to:
    - Provide you with medical treatment and related services
    - Evaluate and improve the quality of medical care provided to all patients.

Note: The choice you make in this Consent Form does *not* allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included?** If you give consent, Bon Secours Hospital, may access **all** of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
    - Mental health conditions
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From.** Information about you in PSYCKES comes from the New York State Medicaid program.

4. **Who May Access Information About You, if You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on Bon Secours Hospital's medical staff who are involved in your medical care; health care providers who are covering or on call for Bon Secours Hospital's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Mental Hygiene Legal Services at 845-294-9123; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

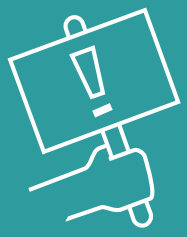
7. **Effective Period.** This Consent Form will remain in effect until three (3) years after the last date you received any medical services, or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to social worker or medical records.You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling 800-597-8481. Note: Organizations that access your health information through _____ while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

The Joint Commission

Speak Up™ For Your Rights



As a patient, you have the right to …

- Be informed about your care.
- Make decisions about your care.
- Refuse care.
- Know the names of your caregivers.
- Be treated with courtesy and respect.
- Be listened to by your caregivers.
- Have an interpreter.
- Receive information in a way that meets your needs, such as if you have impaired vision.
- Religious or spiritual services.
- Copies of your test results and medical records.
- Have a patient advocate with you during your care.
- Privacy of your health information.
- Ask that pictures or videos taken of you be used only to identify you or assist in your care.
- Care that is free from discrimination.

Be active in your care …

- Ask questions.
- Pay attention to instructions from your caregivers.
- Inform caregivers about your medicines, supplements and allergies.
- Share your wishes about life-saving actions, such as being put on a ventilator.

Your advocate can help …

- Get information and ask questions when you cannot.
- Ask for help if you are not getting the care you need.
- Make care decisions when you cannot (so long as he or she is a legal guardian, a health care power of attorney, or has some other legal permission).

Attached are screening/assessment tools for children please review the ages of each assessment and fully
complete.

Parents/Guardians fill out the appropriate information.

The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (weed, oil, or hash, by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice") or "vaping" **THC oil**? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

		No	Yes
4.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

The CRAFFT Interview (version 2.1)

To be orally administered by the clinician

Begin: "*I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.*"

Part A

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none.	# of days
2.	Use any **marijuana** (weed, oil, or hash, by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice") or "vaping" **THC oil**? Put "0" if none.	# of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Say "0" if none.	# of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask CAR question only, then stop**

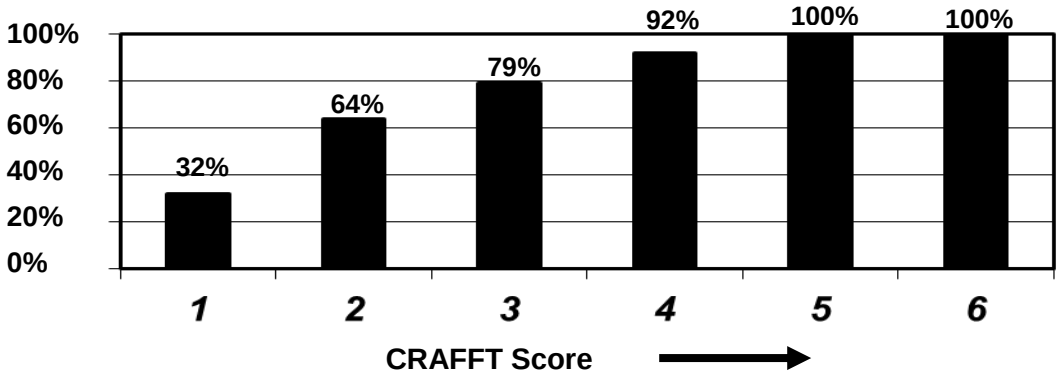
No ☐ → **Ask all six CRAFFT* questions below**

Part B		**No**	**Yes**
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
F	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

***Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions →**

1. Show your patient his/her score on this graph and discuss level of risk for a substance use disorder.

Percent with a DSM-5 Substance Use Disorder by CRAFFT score*



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

2. Use these talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*

2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."

3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."

4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink or use drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*

5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

3. Give patient Contract for Life. Available at www.crafft.org/contract

(617) 355-5433 www.ceasar.org

For more information and versions in other languages, see www.ceasar.org.

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995)*. *E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: _____ Date: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

Please place answer in the box below	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN
13. I worry about sleeping alone.	O	O	O	SP
14. I worry about being as good as other kids.	O	O	O	GD
15. When I get frightened, I feel like things are not real.	O	O	O	PN
16. I have nightmares about something bad happening to my parents.	O	O	O	SP
17. I worry about going to school.	O	O	O	SH
18. When I get frightened, my heart beats fast.	O	O	O	PN
19. I get shaky.	O	O	O	PN
20. I have nightmares about something bad happening to me.	O	O	O	SP

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	GD
22. When I get frightened, I sweat a lot.	O	O	O	PN
23. I am a worrier.	O	O	O	GD
24. I get really frightened for no reason at all.	O	O	O	PN
25. I am afraid to be alone in the house.	O	O	O	SP
26. It is hard for me to talk with people I don't know well.	O	O	O	SC
27. When I get frightened, I feel like I am choking.	O	O	O	PN
28. People tell me that I worry too much.	O	O	O	GD
29. I don't like to be away from my family.	O	O	O	SP
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. I worry that something bad might happen to my parents.	O	O	O	SP
32. I feel shy with people I don't know well.	O	O	O	SC
33. I worry about what is going to happen in the future.	O	O	O	GD
34. When I get frightened, I feel like throwing up.	O	O	O	PN
35. I worry about how well I do things.	O	O	O	GD
36. I am scared to go to school.	O	O	O	SH
37. I worry about things that have already happened.	O	O	O	GD
38. When I get frightened, I feel dizzy.	O	O	O	PN
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	SC
41. I am shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

Scoring Sheet for SCARED ANXIETY QUESTIONNAIRE

In the table below, enter the score for each question to the right of the question number. Add the scores in each column and enter the total at the bottom of the column. Add the scores across the "TOTAL" row to calculate the overall score.

Panic Disorder or Significant Somatic Symptoms		Generalized Anxiety Disorder		Separation Anxiety Disorder		Social Anxiety Disorder		Significant School Avoidance		
Question Number	**Score**	**Question Number**	**Score**	**Question Number**	**Score**	**Question Number**	**Score**	**Question Number**	**Score**	
#1		#5		#4		#3		#2		
#6		#7		#8		#10		#11		
#9		#14		#13		#26		#17		
#12		#21		#16		#32		#36		
#15		#23		#20		#39				
#18		#28		#25		#40				
#19		#33		#29		#41				
#22		#35		#31						
#24		#37								
#27										
#30										
#34										**Overall Score**
#38										
TOTAL	=	+	=	+	=	+	=	+	=	

A total score of **≥25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 40 are more specific. TOTAL =

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. PN =

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. GD =

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**. SP =

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. SC =

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. SH =

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date**: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	Please enter answers in the box	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When my child feels frightened, it is hard for him/her to breathe	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	My child worries about things working out for him/her	o	o	o
22.	When my child gets frightened, he/she sweats a lot	o	o	o
23.	My child is a worrier	o	o	o
24.	My child gets really frightened for no reason at all	o	o	o
25.	My child is afraid to be alone in the house	o	o	o
26.	It is hard for my child to talk with people he/she doesn't know well	o	o	o
27.	When my child gets frightened, he/she feels like he/she is choking	o	o	o
28.	People tell me that my child worries too much	o	o	o
29.	My child doesn't like to be away from his/her family	o	o	o
30.	My child is afraid of having anxiety (or panic) attacks	o	o	o
31.	My child worries that something bad might happen to his/her parents	o	o	o
32.	My child feels shy with people he/she doesn't know well	o	o	o
33.	My child worries about what is going to happen in the future	o	o	o
34.	When my child gets frightened, he/she feels like throwing up	o	o	o
35.	My child worries about how well he/she does things	o	o	o
36.	My child is scared to go to school	o	o	o
37.	My child worries about things that have already happened	o	o	o
38.	When my child gets frightened, he/she feels dizzy	o	o	o
39.	My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	o	o	o
41.	My child is shy	o	o	o

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

SCARED Rating Scale Scoring Aide

Use with Parent and Child Versions

Question	Panic/ Somatic	Generalized Anxiety	Separation	Social	School Avoidance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
Total					
	Cutoff = 7	Cutoff = 9	Cutoff = 5	Cutoff = 8	Cutoff = 3

Total anxiety ≥ 25

0 = not true or hardly true
1 = somewhat true or sometimes true
2 = very true or often true

SCORING

A total score of **≥ 25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate Significant **School Avoidance**.

Thank you for filling out our intake packet for Frawley Clinic. Please remember to email all information back to the clinic before your scheduled appointment. We thank you for your cooperation and choosing the Frawley Clinic!

Best,
Frawley Clinic Staff
845-368-5222