PATIENT PARTICULARS
INSURANCE INFORMATION
Behavioral Health Services
Agnesian HealthCare
Doll& Asssociates

Patient name: _____ _____ _____ Date of birth: _____ Age: _____
(last) (first) (M)

Patient address: _____ Patient phone (home): _____

_____ (business): _____

_____ Patient Social Security No.: _____

_____ Referred by: _____
self/physician name/social worker name

Occupation: _____

If student, name of school: _____ Address & phone number of referent if other than self: _____

Insured's employer: _____

Patient's primary care physician: _____ Address: _____ Phone: _____

Emergency contact person: Name: _____ Phone no.: (home) _____ (work): _____

Relationship to patient: _____

Continued on reverse side

INSURANCE INFORMATION:

Primary insured name: _____ Insurance ID: _____ Group:: _____

Insured's social security no.: _____ Insured's date of birth: _____

Address if different than patient: _____ Zip: _____

Employer: _____ Insurance carrier: _____

Phone number of insured: _____ Relationship to patient: _____

SECONDARY INSURANCE INFORMATION:

Primary insured name: _____ Insurance ID: _____ Group:: _____

Insured's social security no.: _____ Insured's date of birth: _____

Address if different than patient: _____ Zip: _____

Employer: _____ Insurance carrier: _____

Phone number of insured: _____ Relationship to patient: _____

LABEL

THERAPIST FEE SCHEDULE

JANUARY 1, 2020 - DECEMBER 31, 2020

Doll & Associates

Agnesian HealthCare

PSYCHOTHERAPY

Initial Evaluation

90791	PhD/PsyD	$318.00
	Master Level	$306.00

30 Minute Psychotherapy

90832	PhD/PsyD	$159.00
	Master Level	$154.00

45 Minute Psychotherapy

90834	PhD/PsyD	$248.00
	Master Level	$234.00

75 Minute Psychotherapy

90837	PhD/PsyD	$312.00
	Master Level	$283.00

Crisis - First 60 Minutes

90839	PhD/PsyD	$248.00
	Master Level	$234.00

Crisis - Additional 30 minutes

90840	PhD/PsyD	$158.00
	Master Level	$154.00

Group Psychotherapy

90853	PhD/PsyD	$142.00
	Master Level...	$142.00

90785 Interactive Complexity

	PhD/PsyD	$63.00
	Master Level	$54.00

Family Psychotherapy without patient

90846	PhD/PsyD	$248.00
	Master Level	$234.00

Family Psychotherapy with patient

90847	PhD/PsyD	$248.00
	Master Level	$234.00

Doctoral Interns are supervised by Beth Rogers-Doll,PhD & Sarah Arnold, PsyD

Master Level interns are supervised by Anne Brunette, MSW, LCSW

TESTING

Psychological Testing Evaluation - First hour

96130	PhD/PsyD	$608.00

Psychological Testing each additional hour

96131	PhD/PsyD	$460.00

Neuropsychological Testing Evaluation - First hour

96132	PhD/PsyD	$602.00

Neuropsychological Testing Evaluation each additional hour

96133	PhD/PsyD	$457.00

Psychological/Neuropsychological Testing Administation and Scoring first 30 minutes - 2 or more tests

96136	PhD/PsyD	$131.00

Psychological/Neuropsychological Testing Administation and Scoring each additional 30 minutes - 2 or more tests

96137	PhD/PsyD	$102.00

CR-0060

LABEL

- We strongly recommend you become familiar with your insurance policy regarding the extent of mental health and/or addiction insurance coverage. ***You*** should check to see the requirements of your plan before your next appointment. The fee allowed or paid by your insurance and the co-pay may vary with the policy or contract Agnesian Healthcare has with your carrier. It is your responsibility to pay any portion of the bill not covered by insurance.
- **Co-payment is due at the time services are provided.**
- If you are self-pay, you will be **required to pay in full the session fee at the time of each appointment.**
- Doll & Associates will not enter into any dispute with your insurance carrier. Should they fail to pay, you are responsible for the unpaid balance in full thirty (30) days after the invoice date.
- An individual may be involuntarily discharged from treatment services for their inability to pay for services under certain circumstances. Doll & Associates may turn over any outstanding bill to a collection agency if appropriate and adequate payment arrangements are not reached.
- If we can be of any assistance in helping you understand your coverage, please feel free to ask us. For questions regarding billing, please call (920) 907-8201.
- A full listing of all fees within Doll & Associates is posted in the waiting room and a copy can be obtained from the receptionist
- Missed sessions and those canceled without 24 hour notice shall be billed at one half the session fee. More than two missed appointments or cancellations with less than 24 hour notice is grounds for dismissal. Patient is responsible for this amount. These fees are not billed to insurance.

I have read and understand the above fee policy information.

_____
SIGNATURE OF PATIENT (if under 18, parent or guardian signature)

_____
DATE TIME

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

Name of Patient/Resident

Street Address

City, State, Zip code

Date of Birth

Phone #

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to SSM Health. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

2. I AUTHORIZE THE FOLLOWING FACILITY TO DISCLOSE THE HEALTH INFORMATION IDENTIFIED IN SECTION 5:

- ❑ St. Agnes Hospital
- ❑ St. Francis Home
- ❑ Waupun Memorial Hospital
- ❑ Consultants Laboratory
- ❑ Ripon Medical Center
- ❑ Agnesian HealthCare Enterprises
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

☑ Other: Doll and Associates Phone: (920) 907-8201

Address: 40 Camelot Drive Fax: (920) 907-8209

Fond du Lac, WI 54935

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:
(If Release is to Self, State Self)

(Name of Physician/Health Care Facility/Other)

(Street Address)

(City, State, Zip code)

(Fax number)

For Pick-Ups, please list who will pick-up records:
Name:

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date: ____/____/____ (MM / DD / YYYY)

❑ Worker's Compensation Research ❑ Other (specify):

(CONTINUED ON BACK)

MR-0465

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

FOR THE FOLLOWING DATE(S) OR TIME FRAME: From: ____/____/____ (MM/DD/YYYY) to: ____/____/____ (MM/DD/YYYY)

☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

6. Disclosure may be in the form of: ☑ Photocopies ☑ Fax ❑ Inspection ❑ CD/DVD ☑ Verbal Disclosure ❑ email: _____

7. EXPIRATION

This authorization will expire on ____/____/____ (MM/DD/YYYY). If I do not indicate a date, this will expire one (1) year from the date of my signature below.

A photocopy of this authorization is as valid as the original.

8. SIGNATURE

I understand that this authorization is voluntary. I understand that there may be a charge for copies. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this Authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

9. Prohibition of Disclosure for Substance Use Disorder: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and Wisconsin Statute 51.30). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand I may inspect and receive a copy of the disclosed information.

10. You are entitled to a copy of this authorization after you sign it.

OFFICE USE ONLY **Date of request:** _____

Records sent: _____ Copies by: _____

Initials: _____

Date: _____ Time: _____

Released to: _____

Patient's charge for records: _____

This information was: ❑ Hand carried by patient ❑ Mailed first class

❑ Hand carried by ❑ Express mailed ❑ Fax

❑ Other: _____

Fax form to: ❑ ROI: (920) 926-8910 ❑ Medical Imaging (Films): (920) 926-4868

MR-0465

LABEL

Agnesian HealthCare Enterprises
Christian Home & Rehabilitation Center
Consultants Laboratory
Fond du Lac Regional Clinic
Ripon Medical Center
St. Agnes Hospital
St. Francis Home
Villa Loretto & Villa Rosa
Waupun Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Complete in Full)

1.

Name of Patient/Resident

Street Address

City, State, Zip code

Date of Birth

Phone #

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this Authorization by providing written notice to SSM Health. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

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- ❑ Agnesian HealthCare Enterprises
- ❑ Villa Loretto
- ❑ Villa Rosa
- ❑ Christian Home & Rehabilitation Center
- ❑ Fond du Lac Regional Clinic, site location:

  _____
- ❑ Other: _____

  Address: _____

  _____

3. TO RELEASE PROTECTED HEALTH INFORMATION TO:

(If Release is to Self, State Self)

Doll and Associates

(Name of Physician/Health Care Facility/Other)

40 Camelot Drive

(Street Address)

Fond du Lac, WI 54935

(City, State, Zip code)

(920) 907-8209

(Fax number)

For Pick-Ups, please list who will pick-up records:

Name:_____

4. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable categories)

☑ Continuing Care ❑ Transferring Care

❑ Personal Use ❑ Insurance Eligibility/Benefits ❑ Disability Determination ❑ Legal Investigation ❑ Needed by/Appt. date:_____/_____/_____
MM DD YYYY

❑ Worker's Compensation Research ❑ Other (specify):_____

(CONTINUED ON BACK)

MR-0465

LABEL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (continued)

5. HEALTH INFORMATION TO BE RELEASED:

❑ Office Visits ❑ Procedures ❑ Emergency Room Report ❑ Discharge Summary ❑ History & Physical Exam ❑ Operative Reports

❑ Immunization Records ❑ Lab Reports

❑ Medical Images (specify): _____ ❑ Billing Records (specify) _____

☑ Specific information related to: BH diagnoses, treatment plan/summary, BH assessments, psychotherapy notes, discharge summary, transfer summary, psychological testing, attendance history, mental status exam

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☑ Information regarding mental health, substance use disorder, 42CFR Part 2, AIDS or AIDS-related illness, HIV/AIDS test results, developmental disabilities, and/or sexually transmitted infection, unless I limit the disclosure to exclude the following: _____

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Signature: _____ Date: _____

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Representative's Name (please print): _____ Patient is: ❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority: ❑ Legal Guardian ❑ Parent of Minor ❑ Spouse of Deceased ❑ Health Care Agent: _____

❑ Personal Representative/Domestic Partner of Deceased ❑ Other _____

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10. You are entitled to a copy of this authorization after you sign it.

OFFICE USE ONLY **Date of request:** _____

Records sent: _____ Copies by: _____

Initials: _____

Date: _____ Time: _____

Released to: _____

Patient's charge for records: _____

This information was: ❑ Hand carried by patient ❑ Mailed first class

❑ Hand carried by ❑ Express mailed ❑ Fax

❑ Other: _____

Fax form to: ❑ ROI: (920) 926-8910 ❑ Medical Imaging (Films): (920) 926-4868

MR-0465

LABEL OR

LAST NAME FIRST NAME

DATE OF BIRTH

BILL OF RIGHTS

Behavioral Health Services
Agnesian HealthCare

Agnesian HealthCare is required by law to maintain the privacy of your mental health and medical information. All providers of services in this clinic follow the same privacy rules. Whenever a MD, psychotherapist or other provider treats you, mental health and/or medical information is created. This information may be written (e.g., information gathered from you during your treatment which becomes part of your record), spoken (e.g., MD or psychotherapists discussing your health status), or electronic (e.g., billing information saved on computer, etc.)

The law permits Agnesian HealthCare to use or disclose health information for the following routine activities: treatment, payment, health care operations, communication with you, and in some instances, appointment reminders.

Examples of Permitted Uses and Disclosures of Health Information without consent include: child abuse, adult and domestic abuse, mandated clinic review, judicial or administrative proceedings, serious threat to health or safety, worker's compensation, coroners, medical examiners and funeral directors.

Activities that Require Your Written Permission (Authorization): We must receive your written authorization to release your information for purposes outside of treatment, payment and healthcare operations.

When you receive services for mental health, alcoholism, drug abuse or a developmental disability as an outpatient, you have the following rights under WI Statute Sec 51.61:

Treatment Rights and Related Areas

- To receive prompt and adequate treatment.
- To request restriction on uses and disclosures of your mental health or medical information.
- To be treated in the least restrictive environment possible.
- To be free from having unreasonable or arbitrary decisions made about you.
- To refuse any treatment or medications because of the voluntary nature of therapy, or because your religious beliefs prohibit it.
- To refuse to participate in any drastic treatment or experimental research.
- To be free from unnecessary or excessive medications.
- To be free from physical restraint except in emergencies where you pose a danger to yourself, others, or are damaging property.

Rights of Access to Court

- To petition the court for review of any civil commitment proceedings that might be initiated.
- To be considered legally competent unless determined otherwise by a court and to make your own decisions.
- To bring legal action for damages against those who violate your rights.

(Additional rights are listed on the back side of this handout)

BHO-0220

LABEL OR

LAST NAME FIRST NAME

DATE OF BIRTH

BILL OF RIGHTS

Behavioral Health Services
Agnesian HealthCare

ORDER FROM PRINTING

Communication and Privacy Rights

- To refuse to be filmed or taped without your consent.
- To request how we may contact you.
- To inspect and copy your mental health records, medical records or billing information.
- To request corrections to your mental health, medical or billing records.
- To receive a list of certain disclosures.
- To have your treatment records and conversations kept confidential at all times (Sec. 51.61 Stats), information being released only with your written consent, except where you represent a threat to yourself and/or others, or the records are requested by a court of law.
- The treatment professionals affiliated with Agnesian Healthcare are mandated by law to report instances of suspected child abuse or neglect and/or elder abuse/neglect.
- To have access to your treatment records after discharge and during treatment with the approval of the medical director or his/her designee and to have access at all times to records of medications prescribed or any treatment you receive for physical health reasons.

Complaints and Grievances

- To implement the grievance procedure explained to you by your treatment provider at any time you have a concern or believe your rights have been violated.
- To ask for and receive a copy of the grievance procedure currently in place.
- To contact the complaint investigator or his/her designee and file a complaint or learn more about the process.

I acknowledge that I fully understand the information listed above.

Patient/Guardian Signature Date Time

BHO-0220

LABEL

NAME:_____

INFORMED CONSENT FOR TREATMENT

Behavioral Health Services
Agnesian HealthCare

BHO 575 (4.25.16) ORDER FROM PRINTING

In meeting with my provider, I have been given information on the following:

1. The results of the assessment including treatment recommendations and the manner in which the treatment will be administered
2. The benefits of the treatment recommendations
3. Possible outcomes and side effects of the treatment recommended.
4. Treatment alternatives.
5. The probable consequences of not receiving the treatment and services
6. Approximate duration and desired outcome of treatment recommended in the treatment plan
7. My rights in receiving outpatient mental health services, including my rights and responsibilities in the development and implementation of an individual treatment plan.
8. The fees that I will be billed for the proposed services.
9. How to use the clinic's grievance procedure.
10. How to obtain emergency mental health services after our normal operating hours dial: 920-926-4290 (inpatient behavioral health unit).
11. How an individual may be discharged from services:
    - Physical or verbally disruptive or threatening behaviors, criminal activity, posing a threat to another individual
    - Represented myself in a fraudulent manner or providing misleading or inaccurate data important to the provision of services or reimbursement.
    - If I have repeatedly scheduled appointments and fail to maintain the appointment or obligations and responsibilities to attend and/or participate in treatment services

I understand that in signing this document I am authorizing the Behavioral Health Department to provide outpatient mental health and/or addiction services to me as discussed with the treatment provider. This consent shall be in effect for twelve (12) months after the date signed. I may withdraw consent for treatment at any time and this must be provided to the clinic in writing.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE DATE TIME

35-1100

LABEL

NAME:_____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION

Behavioral Health Services
Agnesian HealthCare

BHO-70-28 (1.24.19) ORDER FROM PRINTING

There are many important issues which will be discussed as you begin treatment. Of primary concern are the problems you bring to treatment. However, there are other important issues for you to understand and be familiar with as you begin receiving services. We have listed here several key issues which you should understand prior to committing yourself to treatment. Each of these issues should be discussed with you by your provider. If you have any questions, please feel free to ask them.

1. **Confidentiality** - We would like you to be open and comfortable in talking about your concerns. To help you be more comfortable discussing your problems it is important you understand any information you provide is considered confidential. This means we can not share any of it with others without your written consent.

   There are times when the limits of confidentiality do not apply. One such time is when withholding information poses a risk of harm or a clear danger of physical injury. This includes, but is not limited to instances of suspected child abuse and/or neglect, threats of suicide or physical violence to others. Another time is when the courts subpoenas your records.

2. **Insurance** - The diagnosis and/or code number and the dates of outpatient treatment sessions will be provided your insurance carrier for billing purposes. **Signing this authorization below gives us permission to do this.**

3. **Rights** - You have certain rights which are outlined on a separate form: **Patient Bill of Rights. Please read this form carefully.**

4. **Complaints** - You have the right to voice any complaint you have regarding your clinical treatment, therapist, billing or other matters. Some are best discussed with your counselor while others can be discussed with Matt Doll, PhD, Director of Behavioral Health.

5. **Consultation** - Your therapist will discuss your case with a supervisor and consult with other professionals within the Outpatient Behavioral Health Department when they would like to get some suggestions on how to proceed in certain areas. You can ask to meet with the case supervisor if you wish. Any meeting will be charged at their normal fee.

6. **Fees** - The cost of treatment is outlined on the **Fee Policy Sheet.** We ask that you discuss fees and billings concerns with your therapist.

7. **Appointments** - Your therapist will be asking you to make appointments at times convenient to you. We ask that you cancel any appointment you can not make 24 hours before the scheduled time. Failure to do so will result in your being charged one half the therapist's normal fee for a one hour session. You may be directly responsible for this fee as insurance companies do not generally pay for missed appointments.

Consent - I freely consent to the treatment offered me by the staff of Agnesian HealthCare Outpatient Behavioral Health Department. I am aware of my rights as a client. I am aware this authorization will remain in effect while I am in treatment and until payment of services is completed. I can withdraw this consent at any time by submitting a written request to do so.

_____ _____ _____
PATIENT/GUARDIAN SIGNATURE DATE TIME

_____
WITNESS SIGNATURE

_____ _____
DATE TIME

BHO-0070

Name: _____

DOB: _____

OR LABEL

OUTPATIENT EDUCATION NEEDS ASSESSMENT FORM

Behavioral Health Services
Agnesian HealthCare

BHO-360-28 (4.25.16) ORDER FROM PRINTING

1 Information provided by:
❑ Patient (Skip #2) ❑ Parent/Legal Guardian ❑ Significant Other (relationship) _____

2. Patient unable to provide information due to:
❑ Medical Instability ❑ Cognitive Impairment ❑ Minor Child - Age: _____

3. What is your primary language? ❑ English ❑ Spanish ❑ Hmong ❑ Other _____
Translator needed: ❑ Yes ❑ No

4. Do you have difficulty reading? .....❑ No ❑ Yes
Do you need glasses for reading? .....❑ No ❑ Yes
Do you need enlarged print for reading?.....❑ No ❑ Yes
Do you have difficulty hearing a normal speaking voice?.....❑ No ❑ Yes
Comments: _____

5. Do you have any changes in concentration? ❑ No ❑ Yes
If yes, please explain: _____

6. Do you have any changes in memory? ❑ No ❑ Yes
If yes, please explain: _____

7. Would you like to learn more about your mental health/substance abuse problems? ❑ No ❑ Yes
How do you prefer to learn new things? ❑ Written materials ❑ Demonstration ❑ Videos ❑ 1 to 1 explanation
❑ Other: _____

8. Are your emotions affected by your health status? ❑ No change ❑ More anxious ❑ More depressed
❑ Other: _____

9. Do you have any religious/cultural practices that may affect your health care choices? ❑ No ❑ Yes
If yes, please explain: _____

10. Do you have any financial concerns that may affect your health care choices? ❑ No ❑ Yes
If yes, please explain: _____

11. Do you have any physical limitations that affect your level of functioning? ❑ No ❑ Yes
If yes, please explain: _____

_____
PATIENT/GUARDIAN SIGNATURE DATE TIME

_____
STAFF SIGNATURE DATE TIME

BHO-0360

Name: _____

DOB: _____

OR LABEL

PERSONAL HEALTH ASSESSMENT

Behavioral Health Services
Agnesian HealthCare

PRIMARY CARE PROVIDER:

YES **NO**

- ❑ ❑ Do you regularly see a primary care provider?
  Who is your primary care provider? _____
  Where are they located? _____
- ❑ ❑ Have you had a physical in the last year? (*over a year refer to PCP*)? When? _____
- ❑ ❑ Have you had any medical hospitalizations in the last year? If yes, please list: _____
  _____
- ❑ ❑ Do you have any allergies? If yes, please list: _____
  _____
  _____

MEDICATIONS: (include supplements, vitamins, or any over-the-counter medications):

Medication	Dose	Date you started medication	Reason for taking the medication	Medication prescribed by

Name: _____

DOB: _____

OR LABEL

PERSONAL HEALTH ASSESSMENT
Behavioral Health Services
Agnesian HealthCare

SLEEP:

How many hours of sleep do you get a night? _____

YES	NO	If you answer yes, give the reason for the sleep problem if known (mind races/caffeine use etc.) If you have nightmares, can you recall about what?
❑	❑	Do you have problems falling asleep? _____
❑	❑	Do you have nightmares? _____
❑	❑	Do you feel rested when you wake up? _____
❑	❑	Do you use a CPAP machine? _____
❑	❑	Do you take any sleeping medication? _____
❑	❑	Any other sleep issues? _____

NUTRITION:

How many meals do you eat per day? _____

How much caffeine do you drink per day? _____

How many energy drinks do you drink per day? _____

Beliefs/attitude about food

YES	NO	How much and reason why (stress, diet, etc.)
❑	❑	Have you gained weight in the past year? _____
❑	❑	Have you lost any weight in the past year? _____
❑	❑	Are there any foods you fear (due to calories/fat etc.)? _____
❑	❑	Are there any foods you won't eat (don't like/allergies to etc.)? _____

Behaviors around food

YES	NO	PAST	PRESENT	Comments
❑	❑	❑	❑	Do you purge? (force yourself to vomit)? _____
❑	❑	❑	❑	Do you overeat? _____
❑	❑	❑	❑	Do you restrict your food intake? _____
❑	❑	❑	❑	Do you you take laxatives or diet pills? _____
❑	❑	❑	❑	Do you have negative thoughts about your body or looks? _____

BHO-0010

Name: _____

DOB: _____

OR LABEL

PERSONAL HEALTH ASSESSMENT

Behavioral Health Services
Agnesian HealthCare

EXERCISE:

YES NO

❑ ❑ Do you currently engage in exercise that raises your heart rate?

Type of exercise you engage in? _____

_____

How often per week do you exercise? ❑ 1-2 days ❑ 3-4 days ❑ 5-6 days ❑ 7 days

How long are the exercise sessions? ❑ 0-15 minutes ❑ 15-30 minutes ❑ 30-45 minutes ❑ 45-60 + minutes

SMOKING:

YES NO

❑ ❑ Do you currently use tobacco products? If yes, type: _____

❑ ❑ Have you tried to quit? If yes, how many times? _____

❑ ❑ Do you want resources on how to quit smoking? ❑ Declined

CURRENT/PAST SUBSTANCE USE/ABUSE: *If not applicable, check here:* ❑

Substance	Currently Using	Past Use	How often do you use?	Date of last use
Alcohol	❑ Yes ❑ No	❑ Yes ❑ No		
Cocaine	❑ Yes ❑ No	❑ Yes ❑ No		
Heroin	❑ Yes ❑ No	❑ Yes ❑ No		
Marijuana	❑ Yes ❑ No	❑ Yes ❑ No		
Pills	❑ Yes ❑ No	❑ Yes ❑ No		
IV drug use	❑ Yes ❑ No	❑ Yes ❑ No		

FIREARMS:

YES NO

❑ ❑ Are there firearms in the home/apartment?

❑ ❑ Are they locked in a cabinet?

❑ ❑ Is the gun locked?

Name: _____

DOB: _____

OR LABEL

PERSONAL HEALTH ASSESSMENT
Behavioral Health Services
Agnesian HealthCare

PAST/CURRENT MEDICAL HEALTH ISSUES:

Have you been treated for or experienced:

YES	NO	If you answer yes, explain where/how often you experience the condition/length of the illness/are you currently being treated for the pain and by whom.
❑	❑	Do you have muscle tension? _____
❑	❑	Do you have headaches? _____
❑	❑	Do you have migraines? _____
❑	❑	Have you had a traumatic head injury (if yes-open or closed)? _____
❑	❑	Epilepsy or seizure disorder? _____
❑	❑	Heart or lung disease? _____
❑	❑	Hypoglycemia (low blood sugar)? _____
❑	❑	Diabetes? _____
❑	❑	Hypertension (high blood pressure)? _____
❑	❑	Thyroid? _____
❑	❑	Cancer? _____
❑	❑	Arthritis? _____
❑	❑	Have you had multiple episodes of strep throat? _____
❑	❑	Recurrent ear infections? _____
❑	❑	Ever had a broken bone? _____
❑	❑	Are you frequently in pain? _____
❑	❑	Are you seeing anyone for your pain? _____
❑	❑	Have you ever tested positive for TB? _____
❑	❑	Were you treated for TB? _____
❑	❑	Any other medical problems? _____

Name: _____

DOB: _____

OR LABEL

PERSONAL HEALTH ASSESSMENT

Behavioral Health Services
Agnesian HealthCare

RISK FACTORS FOR INFECTIOUS DISEASE:

Have you been treated for or experienced:

YES	NO	If you answer yes, explain where/how often you experience the condition/length of the illness/are you currently being treated for the pain and by whom.
❑	❑	Do you have/had unprotected sex with multiple partners? _____
❑	❑	Have you been treated for a STD _____
❑	❑	Have you tested positive for HIV? _____
❑	❑	Are you currently pregnant? _____
❑	❑	Have you ever had a miscarriage? _____
❑	❑	Have you ever had an abortion? _____
❑	❑	Have you had a blood transfusion? _____

PLEASE CIRCLE THE NUMBER THAT BEST MATCHES YOUR RESPONSE:

Rate your current physical health:

1 2 3 4 5 6 7 8 9 10
Poor Excellent

Is your physical health impairing your current ability to function?

1 2 3 4 5 6 7 8 9 10
Not at all Severely

Rate your current mental health:

1 2 3 4 5 6 7 8 9 10
Poor Excellent

Is your mental health impairing your current ability to function?

1 2 3 4 5 6 7 8 9 10
Not at all Severely

_____
PATIENT/GUARDIAN SIGNATURE

_____
DATE **TIME**

BHO-0010

Outcome Questionnaire (OQ®-45.2) Name:_____ Date:___/___/_____

Instructions:
Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and fill the circle completely under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

	Never	Rarely	Sometimes	Frequently	Almost Always
1. I get along well with others	O	O	O	O	O
2. I tire quickly	O	O	O	O	O
3. I feel no interest in things	O	O	O	O	O
4. I feel stressed at work/school	O	O	O	O	O
5. I blame myself for things	O	O	O	O	O
6. I feel irritated	O	O	O	O	O
7. I feel unhappy in my marriage/significant relationship	O	O	O	O	O
8. I have thoughts of ending my life	O	O	O	O	O
9. I feel weak	O	O	O	O	O
10. I feel fearful	O	O	O	O	O
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	O	O	O	O	O
12. I find my work/school satisfying	O	O	O	O	O
13. I am a happy person	O	O	O	O	O
14. I work/study too much	O	O	O	O	O
15. I feel worthless	O	O	O	O	O
16. I am concerned about family troubles	O	O	O	O	O
17. I have an unfulfilling sex life	O	O	O	O	O
18. I feel lonely	O	O	O	O	O
19. I have frequent arguments	O	O	O	O	O
20. I feel loved and wanted	O	O	O	O	O
21. I enjoy my spare time	O	O	O	O	O
22. I have difficulty concentrating	O	O	O	O	O
23. I feel hopeless about the future	O	O	O	O	O
24. I like myself	O	O	O	O	O
25. Disturbing thoughts come into my mind that I cannot get rid of	O	O	O	O	O
26. I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never")	O	O	O	O	O
27. I have an upset stomach	O	O	O	O	O
28. I am not working/studying as well as I used to	O	O	O	O	O
29. My heart pounds too much	O	O	O	O	O
30. I have trouble getting along with friends and close acquaintances	O	O	O	O	O
31. I am satisfied with my life	O	O	O	O	O
32. I have trouble at work/school because of drinking or drug use (If not applicable, mark "never")	O	O	O	O	O
33. I feel that something bad is going to happen	O	O	O	O	O
34. I have sore muscles	O	O	O	O	O
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	O	O	O	O	O
36. I feel nervous	O	O	O	O	O
37. I feel my love relationships are full and complete	O	O	O	O	O
38. I feel that I am not doing well at work/school	O	O	O	O	O
39. I have too many disagreements at work/school	O	O	O	O	O
40. I feel something is wrong with my mind	O	O	O	O	O
41. I have trouble falling asleep or staying asleep	O	O	O	O	O
42. I feel blue	O	O	O	O	O
43. I am satisfied with my relationships with others	O	O	O	O	O
44. I feel angry enough at work/school to do something I might regret	O	O	O	O	O
45. I have headaches	O	O	O	O	O

Developed by
Michael J. Lambert, Ph.D.
and
Gary M. Burlingame, Ph.D.

For More Information Contact:

AMERICAN PROFESSIONAL CREDENTIALING SERVICES LLC
PO Box 970354
Orem, Utah 84097-0354

E-MAIL:
APCS@OQFAMILY.COM

WEB:
WWW.OQFAMILY.COM
TOLL-FREE: 1-888-MH SCORE, (1-888-647-2673)
FAX: 1-801-434-9730

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns			+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* 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 _____

ACE QUESTIONNAIRE
(Adverse Childhood Event)
Behavioral Health Services
Agnesian HealthCare

PATIENT LABEL

BHO-0016 (A) 4.17.18
ORDER FROM PRINTING

What's My ACE Score?

Print name:_____ **Your DOB:**_____

Patient name: _____ Patient DOB: _____

Relationship to patient *(if being completed by parent/guardian of a minor patient)*: _____

Please answer the following questions related to your personal experience, prior to your 18th birthday.

1. Did a parent or other adult in the household **often or very often**… 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 **often or very often**… 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 **ever**… 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 **often or very often** feel that … No one in your family loved you or thought you were important or special? **or** 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 or very 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. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
   ❑ Yes ❑ No If yes enter 1 _____

7. Was your parent or step parent: **often or very often** pushed, grabbed, slapped, or had something thrown at them? **or sometimes, often, or very 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 _____

Now add up your "Yes" answers: _____
This is your ACE Score.

Please list any other adverse life events that you feel may have had a significant impact on you that were not covered above:

_____
_____
_____
_____
_____

How do you think these events affected your life?

_____
_____
_____
_____

Signature:_____

Date: _____ **Time:** _____

PY-0360

PATIENT LABEL

RESILIENCE QUESTIONNAIRE

Behavioral Health Services
Agnesian HealthCare

BHO-0016.5 **(B)** 4.17.18
ORDER FROM PRINTING

Please check the most accurate answer for each.

1. I believe that my mother loved me when I was little.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

2. I believe that my father loved me when I was little.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it too.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

6. When I was a child, neighbors or my friends' parents seemed to like me.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

8. Someone in my family cared about how I was doing in school.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

9. My family, neighbors and friends talked often about making our lives better.
   ❑ Definitely true ❑ Probably true
   ❑ Probably not true ❑ Definitely not true ❑ Not sure

10. We had rules in our house and were expected to keep them.
    ❑ Definitely true ❑ Probably true
    ❑ Probably not true ❑ Definitely not true ❑ Not sure

11. When I felt really bad, I could almost always find someone I trusted to talk to.
    ❑ Definitely true ❑ Probably true
    ❑ Probably not true ❑ Definitely not true ❑ Not sure

12. As a youth, people noticed that I was capable and could get things done.
    ❑ Definitely true ❑ Probably true
    ❑ Probably not true ❑ Definitely not true ❑ Not sure

13. I was independent and a go-getter.
    ❑ Definitely true ❑ Probably true
    ❑ Probably not true ❑ Definitely not true ❑ Not sure

14. I believed that life is what you make it.
    ❑ Definitely true ❑ Probably true
    ❑ Probably not true ❑ Definitely not true ❑ Not sure

How many of these 14 protective factors did you have as a child and youth? (How many of the 14 were checked "Definitely true" or "Probably true"?)....._____

Of these checked, how many are still true for you?....._____

How do you think these events have affected you?

_____

_____

_____

_____

_____

Completed by:

Signature:_____

Date: _____ **Time:** _____

PY-0360

Date seen:_____
Provider initials:_____
Med Support initials:_____

AGNESIAN HEALTHCARE
A member of SSMHealth

INITIAL PATIENT SATISFACTION SURVEY

DOLL & ASSOCIATES OUTPATIENT BEHAVIORAL HEALTH SERVICES

Name: (optional): _____ **Age:** _____ **Male:** __ **Female:** __

Who did you see for services? _____

Welcome to Outpatient Behavioral Health Services and thank you for coming today. We really appreciate your effort to seek our services and look forward to assisting you in your recovery. It is our intention to exceed your expectations and to provide you with the best experience possible. For us to know how we are doing, we need your feedback. *Your responses are important to us and will be used to help us improve our services. All information will remain confidential.*

1. **I was able to schedule my first appointment in a reasonable period of time.**
   ❑ Yes ❑ No
2. **The provider began our session when it was scheduled to start.**
   ❑ Yes ❑ No
3. **I was informed about patient confidentiality and privacy issues.**
   ❑ Yes ❑ No
4. **I was provided information about my rights as a patient.**
   ❑ Yes ❑ No
5. **I was made aware of treatment recommendations at the end of the session.**
   ❑ Yes ❑ No

Place an "X" in the appropriate box to indicate your experience.

	Always	Usually	Sometimes	Never	N/A
Telephone contact with the receptionist was pleasant.					
During your visit, the receptionist treated you with courtesy and respect.					
During your visit, the provider was polite to you.					
During your visit, the provider treated you with courtesy and respect.					
During your visit, the provider listened carefully to you.					
Before prescribing a medicine for you, the physician told you what the medicine was for.					
If a medicine was prescribed for you, the physician told you what the side effects were in a way you could understand.					

- OVER -

Would you recommend our clinic to a friend, relative or family members?

❑ yes ❑ no

On a scale of 1 to 10 where 1 is the worst clinic possible and 10 the very best possible for you, what number would you use to rate our clinic during your visit?

worst 1 2 3 4 5 6 7 8 9 10 best

Please make any additional comments regarding your care and/or identify what we could have done to improve your experience.

THANK YOU FOR YOUR TIME.