# PATIENT INFORMATION

**DANA DARROW, LCSW**

NAME_____SOCIAL SECURITY #_____
Address_____Email_____
City_____State_____Zip_____
Gender Identity: Male, Female, Non-Binary Sexual Orientation: Heterosexual
Homosexual Lesbian Bisexual Transgender-Female, Transgender-Male
Age_____Birthdate_____Single. Married. Widowed. Separated. Divorced
Employed By_____Occupation_____
Home Phone_____Work/Cell Phone_____
Referred By_____
Emergency Contact_____Phone_____

## Primary Insurance

Person Responsible for Account_____
Relationship to Client_____Birth date_____Social Security #_____
Address (if different)_____Phone_____
City_____State_____Zip_____
Person Responsible Employed By_____Occupation_____
Insurance Company_____Insurance ID Number_____

## Subscriber Information

## (complete if someone else besides you is the primary person insured)

Subscriber Name_____Relation to Client_____
Birthdate_____Phone_____
Address (if different from client's)_____
City_____State_____Zip_____
Subscriber Employer_____Business Phone_____
Insurance Company_____Insurance ID#_____

## Assignment and Release

I, the undersigned, certify that I or my dependent have insurance coverage with
Name of insurance Company_____
and assign directly to my provider all the insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for the charges accumulated. I hereby authorize Dana Darrow, LCSW to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to Dana Darrow, LCSW

_____ _____ _____
Responsible Party Signature Relationship Date

Magellan HEALTHCARE℠

## Informed Consent for Treatment (for all practitioners)

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by _____ (name of provider), a behavioral healthcare provider.

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral healthcare providers directly supervising the services received by the patient.

If the patient is under age 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

- **I have been provided education on my primary diagnosis of** _____

Signature _____ Date _____

Relationship to Patient (if applicable):_____

## Informed Consent for Medication (for use by medication prescribers only)

Name(s) of Medication: _____

_____ (provider prescribing medication) has educated me regarding the medication that has been prescribed to (please check one of the following) _____me, _____my child, or _____a person for whom I am the legal guardian, and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication if the person taking this medication becomes pregnant (including discussing with my doctor my desire to become pregnant or breastfeed before becoming pregnant). I have also been informed of the reason or purpose for which this medication was prescribed.

- **I have been provided education on my primary diagnosis of** _____

Patient Name: _____

Patient/Legal Guardian Signature: _____

Provider's Signature: _____

Date: _____

Magellan HEALTHCARE SM

# Depression Screening



**CLIENT NAME:** **CASE #:**

## Depression

## Center for Epidemiologic Studies Depression (CES-D)

### Scale items:

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking (/) the appropriate space.

| During the past week: | **RARELY** or **NONE** of the time | **SOME** or a **LITTLE** of the time | **OCCASIONALLY** or a **MODERATE** amount of the time | **MOST** or **ALL** of the time |
|---|---|---|---|---|
| | 0-1 days | 1-2 days | 3-4 days | 5-7 days |
| 1. I was bothered by things that usually don't bother me. | ☐ | ☐ | ☐ | ☐ |
| 2. I did not feel like eating; my appetite was poor. | ☐ | ☐ | ☐ | ☐ |
| 3. I felt that I could not shake off the blues even with help from my family. | ☐ | ☐ | ☐ | ☐ |
| 4. I felt that I was just as good as other people. | ☐ | ☐ | ☐ | ☐ |
| 5. I had trouble keeping my mind on what I was doing. | ☐ | ☐ | ☐ | ☐ |
| 6. I felt depressed. | ☐ | ☐ | ☐ | ☐ |
| 7. I felt that everything I did was an effort. | ☐ | ☐ | ☐ | ☐ |
| 8. I felt hopeful about the future. | ☐ | ☐ | ☐ | ☐ |
| 9. I thought my life had been a failure. | ☐ | ☐ | ☐ | ☐ |
| 10. I felt fearful. | ☐ | ☐ | ☐ | ☐ |
| 11. My sleep was restless. | ☐ | ☐ | ☐ | ☐ |
| 12. I was happy. | ☐ | ☐ | ☐ | ☐ |
| 13. I talked less than usual. | ☐ | ☐ | ☐ | ☐ |
| 14. I felt lonely. | ☐ | ☐ | ☐ | ☐ |
| 15. People were unfriendly. | ☐ | ☐ | ☐ | ☐ |
| 16. I enjoyed life. | ☐ | ☐ | ☐ | ☐ |
| 17. I had crying spells. | ☐ | ☐ | ☐ | ☐ |
| 18. I felt sad. | ☐ | ☐ | ☐ | ☐ |
| 19. I felt that people disliked me. | ☐ | ☐ | ☐ | ☐ |
| 20. I could not get "going." | ☐ | ☐ | ☐ | ☐ |

# Depression Screening



**CLIENT NAME:** _____ **CASE/CLIENT DATA FORM (CDF) #** _____

**References:**

Hann, D., Winter, K., & Jacobsen, P. (1999). Measurement of depressive symptoms in cancer patients: Evaluation of the Center for Epidemiological Studies

(CES-D). Journal of Psychosomatic Research, 46, 437-443.

Radloff, L. S. (1997). The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement, 1, 385-401.

**Scoring:**

| **Item weights:** | **RARELY** or **NONE** of the time | **SOME** or a **LITTLE** of the time | **OCCASIONALLY** or a **MODERATE** amount of the time | **MOST** or **ALL** of the time |
|---|---|---|---|---|
| | 0-1 days | 1-2 days | 3-4 days | 5-7 days |
| Items 4, 8, 12 and 16 | 3 | 2 | 1 | 0 |
| All other items | 0 | 1 | 2 | 3 |

Score is the sum of the 20 item weights. Possible range is 0-60. If more than four questions are missing answers, do not score the CES-D. A score of 16 or more is considered depressed.

**Clinician Signature** **Credentials** **Date**

 

# Mental Health Intake Form

## Personal Information

Name _____ Date _____

Address _____

Phone _____ Email _____

DOB _____ Sex _____

Primary physician _____ Phone _____

Current therapist _____ Phone _____

## Complaint

What is your major complaint? _____

Start date _____ Have you previously suffered from this complaint? _____

Previous therapist(s) seen for complaint _____

Previous treatment for complaint _____

Aggravating factors _____

Relieving factors _____

## Current Symptoms (Check all that apply)

- ❑ Anxiety
- ❑ Depression
- ❑ Hallucinations
- ❑ Loss of interest
- ❑ Sleep changes
- ❑ Appetite issues
- ❑ Excessive energy
- ❑ Impulsivity
- ❑ Panic attacks
- ❑ Suspiciousness
- ❑ Avoidance
- ❑ Fatigue
- ❑ Irritability
- ❑ Racing thoughts
- ❑ Crying spells
- ❑ Guilt
- ❑ Libido changes
- ❑ Risky activity

## Medical History

Exercise frequency _____ Exercise type(s) _____

Allergies _____

What medications are you currently using? _____

Previous diagnoses/mental health treatment _____

Previously treated by _____

Previous medications _____

Dates treated _____

Previous medical conditions _____

Previous surgeries _____

## Family History

Were you adopted? _____ If yes, at what age? _____

How is your relationship with your mother? _____

How is your relationship with your father? _____

Siblings and their ages _____

Are your parents married? _____

Did your parents divorce? ❑ Yes ❑ No If yes, how old were you? _____

Did your parents remarry? ❑ Yes ❑ No If yes, how old were you? _____

Who raised you? _____

Family member medical conditions _____

Family member mental conditions _____

Treated with medication? ❑ Yes ❑ No If yes, which medications? _____

## Family History

Where did you grow up? _____

How often did you move and where? _____

How old were you when you left home? _____

## Family History, continued

Have any immediate family members died? ❑ Yes ❑ No If yes, who? _____

Have any immediate family members committed suicide? ❑ Yes ❑ No If yes, who? _____

Describe any neglect you suffered and by whom _____

Trauma suffered and by whom _____

Abuse suffered and by whom _____

Highest education level completed _____

Date completed and location _____

Have you served in the military? ❑ Yes ❑ No If yes, where? _____

Dates of service _____ Highest rank achieved _____

## Present Situation

Work ❑ Full-time ❑ Part-time ❑ Student ❑ Unemployed ❑ Disabled ❑ Retired

Are you married? ❑ Yes ❑ No If yes, date of marriage _____

Are you divorced? ❑ Yes ❑ No If yes, date of divorce _____

Prior marriages? ❑ Yes ❑ No If yes, how many _____

What is your sexual orientation? _____ Are you sexually active? _____

How is your relationship with your partner? _____

Do you have children? ❑ Yes ❑ No If yes, dates of birth _____

How is your relationship with your child(ren)? _____

List anyone else who lives with you _____

Are you a member of a religion/spiritual group? _____

What is your level of involvement? _____

Have you ever been arrested? ❑ Yes ❑ No If yes, when and why? _____

## Have you ever tried the following? (Check all that apply)

| | | | |
|---|---|---|---|
| ❑ Alcohol | ❑ Tobacco | ❑ Marijuana | ❑ Hallucinogens (LSD) |
| ❑ Heroin | ❑ Methamphetamines | ❑ Cocaine | ❑ Stimulants (Pills) |
| ❑ Ecstasy | ❑ Methadone | ❑ Tranquilizers | ❑ Painkillers |

If yes to any, list frequency/date of use _____

_____

Have you been treated for drug or alcohol abuse? ❑ Yes ❑ No If yes, when? _____

For which substances? _____

Do you smoke? ❑ Yes ❑ No If yes, how many per day? _____

Do you drink caffeinated beverages? ❑ Yes ❑ No If yes, how many per day? _____

Have you ever abused prescription drugs? _____ If yes, which ones? _____

## Anything Else You Want Your Therapist to Know

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

# Authorization to Disclose Protected Health Information to Primary Care Physician

(Sample form)

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow y our Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

## Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP

My Primary Care Physician is _____

Address _____

Telephone Number: _____

☐ I agree to release only mediation information to my PCP

☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____

Patient Signature Date

## Patient Rights:

- You can end this authorization (permission to use or disclose information) any time by contacting:_____
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use of disclose information

## Information to be completed by Behavioral Health Provider

I saw _____ on _____ for _____

(Patient Name) (Date) (Reason/Diagnosis)

Summary:

_____

_____

_____

_____

_____

_____

Provider: Please send a copy of this signed form to the PCP and keep the original in the treatment record.

# Telemental Health Informed Consent Form

I _____ [name of patient(s)] hereby consent to engaging in telemental health psychotherapy with Dana Darrow, LCSW. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. I understand that telemental health also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to telemental health:

I understand that it is my responsibility to make sure during video conferencing that my location is confidential and that no one can hear sessions. I understand that recording my sessions is prohibited.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

The laws that protect the confidentiality of my medical and mental health information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self and/or others; and where I make my mental or emotional state an issue in a legal proceeding.

In case of emergency my location is:
_____ and contact information for local emergency services is:
_____ I understand Dana Darrow, LCSW may contact my emergency contact and/or appropriate authorities in case of emergency.

I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies.

In addition, I understand that telemental health based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve.

I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.

I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with New Mexico Law.

I understand that I will need to verify that my insurance pays for telemental health.

I agree to use my own equipment during the telehealth session and not equipment owned by another, and I agree to not use my employers computer or network due to fact that my confidentially might be compromised.

I understand that Dana Darrow uses HIPPA-compliant technology to transmit and receive audio and video.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____

Signature of patient/parent/guardian/conservator

_____
_____

If signed by other than patient indicate relationship

_____

Date

“Notice of Privacy Practices”

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my client, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. “Limits of Confidentiality”

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by New Mexico law to report the matter immediately to the New Mexico Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by New Mexico law to immediately make a report and provide relevant information to the New Mexico Department of Welfare or Social Services.

· Health Oversight: New Mexico law requires that licensed psychologists [social workers; counselors] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. New Mexico Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In New Mexico civil court cases, therapy information is not protected by client-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, New Mexico has no statute granting therapist-client privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· Serious Threat to Health or Safety: Under New Mexico law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

*Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.*

III. Client's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

. · Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future.

The notice will contain the effective date . A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: 01/01/2017

**Dana Darrow, LCSW**

**3212 Monte Vista Blvd NE**

**Albuquerque, NM 87106**

Client's Acknowledgement of

Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of [Dana Darrow's] Notice of Privacy Practices."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: _____

Printed Name: _____

Date: _____