evolve
Behavioral Health Services
and Medication Management

Phone: 800-409-6250 Fax: 479-437-3708

Dear patient,

This letter serves to introduce ourselves as your behavioral health care management team and as your review of consent information. When utilizing behavioral health services, you want to ensure that the organization and providers you have chosen have the knowledge, training, and experience to get the best results for you. Evolve Behavioral Health Services strives to maintain a team of behavioral healthcare professionals who go above and beyond to provide quality care to our patients.

We take a collaborative and supportive stance in our approach to treatment with a team that is composed of Behavioral Health Case Coordinators, Licensed Certified Social Workers, Licensed Professional Counselors, Licensed Practical Nurses, and Board Certified Psychiatric Mental Health Nurse Practitioners that will work with your Healthy Connections primary care provider to provide the highest quality of care possible for our patients. This means that at times we may need to discuss certain information with your treatment team such as medication side effects, symptoms, diagnosis, and treatment goals and objectives. We want to assure you that personal details you share within your sessions are not shared as part of the treatment team process due to your right to confidentiality.

Confidentiality is your right to keep private the information shared by you within the behavioral health process. It will not be released to any other individuals or agencies without your written consent. It is important that you know that your information is not shared except within certain special circumstances which include: when required by law (legal subpoena); when documents are needed to comply with insurance policies for payment; under situation deemed potentially life threatening to yourself or others; and in situations involving abuse and/or neglect of children, elderly, or disabled persons.

The successful achievement of your behavioral healthcare goals is dependent upon attending your appointments, both for therapy and for medication management. Due to a high volume of patients needing behavioral healthcare services it is imperative that we have a clear, consistent no show policy. Our no show policy here at Evolve is as follows: a patient who no shows a new therapy or medication management intake will need a new referral from their provider to be rescheduled; an existing patient who no shows a therapy or medication management appointment can have any future appointments cancelled and may not be rescheduled. We know this policy is strict but it is also necessary to ensure that our patient care schedules are optimized to provide services to those patients who are committed to their treatment goals. We encourage you to reach out to one of our Behavioral Health Case Coordinators on our Evolve phone line if you need to cancel and/or reschedule your appointment or if you have encountered extenuating circumstances that have lead to a no show. We will make every effort to help you make another appointment that fits with your schedule.

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We will strive to provide you the highest quality services, to assist you in as respectful and efficient a manner as possible, to maintain professional behavior consistent with ethics of our profession, and to work as briefly as you will allow to achieve your treatment goals. The length of services needed for each patient varies depending upon needs and participation. Behavioral health services such as therapy and medication management have many benefits such as promoting positive change and growth. There can also be risks associated with these services such as distress from resurfacing memories, high levels of emotion or unexpected physical sensations, flashbacks, dreams, and symptoms or feelings that get worse before improving. These memories and emotions may be unwanted or feel uncomfortable but patients that experience these still have every capability of healing and growing through this process. If it is ever evident that your provider does not possess the expertise necessary to assist you, or if for other reasons progress is not evident we can pursue any of the following strategies: evaluate the possible blockages to progress and develop an alternative therapeutic approach, refer you to another provider, or terminate services.

If you choose to participate in psychiatric medication management it is imperative that you agree to see only one psychiatric medication provider. Our providers cannot ensure that you are receiving the medications that will provide you with optimum results if you are receiving medications from other providers. It is the patient's responsibility to inform their medication management provider of any psychiatric medications they are receiving from other providers. If you experience any side effects and/or adverse reactions to medications prescribed while under our care please contact the behavioral health nurse that is working with your medication management provider. It is the patient's responsibility to call our Evolve patient care team, either BH Case Coordinator or BH Nurse, when refills are needed for your medications. To ensure that you receive your refills as needed please call at least a week in advance.

Welcome to Evolve Behavioral Health Services at Healthy Connections Incorporated, we look forward to serving you!

I attest that I have read and understand this information. I also verify that if signing this consent as the parent/legal guardian of a minor, that I am legally authorized to do so.

_____ _____

Patient or Parent/Legal Guardian Date

Healthy Connections Community Health Network
Medical • Dental • Behavioral Health • Outreach

evolve TeleHealth

Informed Consent for Telemedicine Services

PATIENT NAME: _____ Email address: _____ (your email must be listed in order to do telemedicine) LOCATION OF PATIENT: _____	DATE OF BIRTH: _____	MEDICAL RECORD#: _____
MEDICAL PROVIDER NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____	DATE CONSENT DISCUSSED: _____	

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and/or video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her Medical Providers office (or at a remote site) while the Medical Provider(s) obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision made by the Medical Provider and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Medical Provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my Medical Provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my Medical Provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize the above named provider to use telemedicine in the course of my diagnosis and treatment.

Patient Signature	
Parent/Guardian Signature	
Witness Signature	

A copy of the consent will be provided upon request.

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 _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

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

1. Did a parent or other adult in the household **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** …
   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
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **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** 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. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   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 _____

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

HEALTHY CONNECTIONS: BEHAVIORAL HEALTH CONSULT SCREENING INFORMATION

Name: _____ **Date of Birth:** _____

Who referred you for treatment: _____ Primary Care Physician (PCP): _____

Main reason you want to be seen: _____

Allergies: YES NO if so list: _____

Tobacco: Do you smoke or use tobacco: YES NO How much per week? _____

Are you a former smoker: YES NO If so, when did you stop? NEVER SMOKER

Diet: Do you eat a healthy-balanced diet: YES NO

Marital Status: Single Married Married (Common Law) Separated

Divorced (how many times?_____) Divorced/Remarried Widowed Widowed/Remarried

Education: Current Grade_____ High School Graduate Last Grade completed:_____

GED Some College/No Degree Associates Bachelors Master's Degree Technical School

Military Service: Never Served Army Navy Air Force Marines Coast Guard Nat'l Guard

Reason for Discharge: Honorable Dishonorable Medical Other:_____

Occupation: Working full-time Part-time Unemployed Applying for Disability Retired Disabled

Legal History: No legal history Active probation Active parole Previous incarceration Previous probation

Convicted of: _____ Dates: _____

Charges Pending: YES NO

Substance Use: Do you drink alcohol? YES NO How many drinks per day? ____ week?_____

Have you ever, or do you now use street drugs? YES NO

If so, what are you using and how often?_____

Last time used?_____

Significant Losses: YES NO If so, who, what, when?_____

Spiritual: Do you belong to a particular religion or spiritual group? YES NO

If yes, How involved are you?_____ Do you find it to be: Helpful More Stressful

Family Psychiatric History: (List Mom, Dad, Sibling, Grandparent, Aunt, Uncle)

Anxiety: _____

Bipolar Disorder: _____

Depression: _____

Eating Disorder: _____

Obsessive Compulsive: _____

Personality Disorder: _____

Post Traumatic Stress Disorder: _____

Schizophrenia: _____

Substance Abuse: _____

Suicide: _____

Violence: _____

Other: _____

PLEASE CIRCLE THE FOLLOWING THAT CURRENTLY APPLY:

Depression:

Sad Feeling of hopelessness Loss of interest in Activities Irritability

Crying Spells Feelings of helplessness Feelings of worthlessness

Suicidal Thoughts:

None Thoughts that life is not worth living Thoughts of hurting self

Plans to hurt self Previous attempt to harm self Date of last attempt_____

Self Harm:

None Cutting Hitting self Skin picking Food restriction

Hair pulling Other_____

Previous attempt to harm self_____ Date of last attempt_____

Homicidal Thoughts:

None Thoughts of harming others Plans to harm others

Previous attempts at harming others Date of last attempt_____

Sleep Disturbance:

Sleeps well Wakes Frequently Trouble falling asleep Sleep apnea

Anxiety:

None Anxious Worries A Lot Panic Attacks Trouble leaving home

Post-Traumatic Stress Symptoms:

None	Flashbacks	Nightmares	Startle Response	Phobias
Guilt	Withdrawing	Spacing out	Sleep Disturbance	Irritability
Feeling Numb	Panic Attacks	Social Withdraw		

Traumatic/Abusive Experiences:

None	Physical Abuse	Exposure to Domestic Violence	Exposure to Violence
Neglect	Verbal Abuse	Childhood Sexual Abuse	Emotional Abuse
Bullied	Sexual Assault	Separation from Parent or Caregiver	
Foster Care/Residential Treatment		Extreme Poverty	Homelessness
Natural Disasters		Prison	Military Combat
Head Injury/TBI Chronic/Life		Threatening Illness	Car Accidents
Attacked By Animal		Serious Accidents or Falls	Near drowning
Divorce/Abandonment		Significant losses	Mugged/Robbed
Parental Substance Abuse		Parental Mental Illness	Parental Imprisonment
Multiple Surgeries		Other (please explain):_____	

Treatment or Counseling History:

No Previous Psychiatric Care	No Previous Counseling or Therapy	
Previous Psychiatric Evaluation/Treatment	Dates: _____	Doctor/Agency: _____
Previous Counselor/Therapist	Dates: _____	Therapist/Agency: _____
Previous psychiatric hospitalizations:	Dates: _____	Hospital: _____

What is the most important thing you want help with today?

_____

_____

_____

Additional Social History Questions

Housing: Own home Renting Homeless Shelter Living with relatives/friends

Living with: Alone Spouse Significant other Children Siblings Friends Relatives

Caffeine Usage: Tea Coffee Soda Energy Drinks How much daily? _____

Do you have guns in your home: YES NO Are they secure? YES NO How? _____

Exercise level: None Moderate Intense What type of exercise? _____

Hobbies/Activities: _____

Who is your support? _____

Number of siblings: _____ Number of children: _____

General Stress Level: Low Moderate High

List Stressors: _____

Pregnant: YES NO

Caregiver: YES NO Who and how often? _____

Able to Care for self: YES NO

Do you have pets? YES NO What kind? _____

Supplements/Vitamins: _____

List current medications with dosage(please list dosage, how often, last taken, if effective):

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

List previous psychiatric medications(please list dosage, how often, last taken, if effective):

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Medication_____Dosage:_____How often taken:_____
Last taken:_____Effective: Yes No

Controlled Substance Treatment Agreement

(*Defined as: Schedule II, III, IV, V to include all drugs considered narcotics or so classified, amphetamines, benzodiazepines, anxiolytics, muscle relaxants, and other drugs of potential abuse)*

I_____, DOB_____/____/____ agree to the following conditions to continue receiving CONTROLLED SUBSTANCES from my provider. (Please INITIAL after reading each statement):

1. _____(initial) I have a chronic condition that currently requires the prescription of one or more controlled substances, as defined above, to either maintain or improve my ability to function. The risk include addiction, side effects including drowsiness, and potential benefits control of symptoms and increased functional status of this medications have been discussed with me, including the potential problems related to abuse and diversion.
2. _____(initial) I will take the medication only as prescribed, and will promptly notify my provider if for any reason I do not follow the directions or I think a change is needed.
3. _____(initial) I will NOT request nor expect another provider to renew my medications. I will NOT call after hours or on weekends for refills or go to the ER, after hour's clinic, or Urgent Care for refills.
4. _____(initial) I understand that lost, misplaced, destroyed, and/or stolen medications, or prescriptions will NOT be replaced and early refills will not be given under any circumstances.
5. _____(initial) I understand that the use of the medication at a greater rate than prescribed will result in my being without medication for a period of time which could cause severe withdrawals and possibly even death.
6. _____(initial) I realize that it is my responsibility to keep others and myself from harm while taking CONTROLLED SUBSTANCES. If there is any questions of impairment of my ability to safely perform any activity, such as driving or operating machinery, I agree that I WILL NOT attempt to perform the activity until my ability to safely do so has been evaluated, or until I have not used the medication for at least four (4) days.
7. _____(initial) I will not use alcohol or any illegal substances while prescribed the medication(s).
8. _____(initial) I agree that I will submit to a blood or urine test, if requested by my provider, before beginning any medication regimen, and randomly thereafter to determine compliance with this agreement and my medical regimen.
9. _____(initial) I agree to bring all unused medications in their original pharmacy containers when requested by provider, for random counts to determine compliance with this agreement and my medical regimen.
10. _____(initial) I will not share, sell , or trade my medications with anyone for any reason, especially money, goods, or services.
11. _____(initial) In accordance with DEA regulations, if any of my controlled substances are lost and or stolen, I will file a police report within 10 days and present report to both my provider and my pharmacy.
12. _____(initial) I will properly dispose of unused CONTROLLED SUBSTANCES.

13. _____(initial) I understand that an important part of my disease management may include non-controlled substance medication therapies, relaxation therapy, physical therapy, psychiatric care, and possibly referral to pain management, and/or an addiction specialist. I understand that if I fail to follow through with my entire treatment plan, my CONTROLLED SUBSTANCES may be discontinued.
14. _____(initial) I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of CONTROLLED SUBSTANCES. I also authorized my provider, his/her staff, and associates, and any pharmacy to cooperate fully with any investigation of the possible misuse, sale, or other diversion of such medication and to provide a copy of this agreement to the pharmacy listed above or any other pharmacy or care provider requesting this information.
15. _____(initial) I understand that the goal of CONTROLLED SUBSTANCES therapy is to control or manage symptoms and maximize functional status and that I may at some point be instructed to taper and discontinue the current medication or change to another therapy.
16. _____(initial) I agree to meet regularly with my provider to assess my condition and monitor my compliance with the prescribed regimen and to consider the possibility of discontinuing all CONTROLLED SUBSTANCES.
17. _____(initial) I understand that failure to abide by the above guidelines without my provider's consent may result in the CONTROLLED SUBSTANCES being promptly and appropriately tapered or discontinued.
18. _____(initial) I understand that deviation from these guidelines may be grounds for DISMISSAL from Evolve Behavioral Health. This includes failure of or the refusal to complete a drug screen when requested and belligerent behavior with my provider, or staff.
19. _____(initial) My questions have been answered to my satisfaction. I have received a copy of the informed consent statement. I understand that my provider's interest is in getting the most appropriate mental health care for my condition.

X_____ _____ _____

Signature of Patient or Legal Representative Date Time

Relation to Patient: (Please Circle)

Self Parent Guardian Conservator Executive of Estate Power of Attorney Other:_____

(To verify authority, appropriate documentation must be attached by a Legal Representative.)

_____ _____ _____

Witness Date Time

_____ _____ _____

Provider Signature Date Time