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

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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.

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

		Never	Sometimes	Often
1. Complains of aches and pains	1			
2. Spends more time alone	2			
3. Tires easily, has little energy	3			
4. Fidgety, unable to sit still	4			
5. Has trouble with teacher	5			
6. Less interested in school	6			
7. Acts as if driven by a motor	7			
8. Daydreams too much	8			
9. Distracted easily	9			
10. Is afraid of new situations	10			
11. Feels sad, unhappy	11			
12. Is irritable, angry	12			
13. Feels hopeless	13			
14. Has trouble concentrating	14			
15. Less interested in friends	15			
16. Fights with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Is down on him or herself	19			
20. Visits the doctor with doctor finding nothing wrong	20			
21. Has trouble sleeping	21			
22. Worries a lot	22			
23. Wants to be with you more than before	23			
24. Feels he or she is bad	24			
25. Takes unnecessary risks	25			
26. Gets hurt frequently	26			
27. Seems to be having less fun	27			
28. Acts younger than children his or her age	28			
29. Does not listen to rules	29			
30. Does not show feelings	30			
31. Does not understand other people's feelings	31			
32. Teases others	32			
33. Blames others for his or her troubles	33			
34. Takes things that do not belong to him or her	34			
35. Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? ( ) N ( ) Y

Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Pediatric Symptom Checklist—Youth Report (Y-PSC)

Please mark under the heading that best fits you:

		Never	Sometimes	Often
1. Complain of aches or pains	1			
2. Spend more time alone	2			
3. Tire easily, little energy	3			
4. Fidgety, unable to sit still	4			
5. Have trouble with teacher	5			
6. Less interested in school	6			
7. Act as if driven by motor	7			
8. Daydream too much	8			
9. Distract easily	9			
10. Are afraid of new situations	10			
11. Feel sad, unhappy	11			
12. Are irritable, angry	12			
13. Feel hopeless	13			
14. Have trouble concentrating	14			
15. Less interested in friends	15			
16. Fight with other children	16			
17. Absent from school	17			
18. School grades dropping	18			
19. Down on yourself	19			
20. Visit doctor with doctor finding nothing wrong	20			
21. Have trouble sleeping	21			
22. Worry a lot	22			
23. Want to be with parent more than before	23			
24. Feel that you are bad	24			
25. Take unnecessary risks	25			
26. Get hurt frequently	26			
27. Seem to be having less fun	27			
28. Act younger than children your age	28			
29. Do not listen to rules	29			
30. Do not show feelings	30			
31. Do not understand other people's feelings	31			
32. Tease others	32			
33. Blame others for your troubles	33			
34. Take things that do not belong to you	34			
35. Refuse to share	35			

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

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HEALTHY CONNECTIONS: CHILD BEHAVIORAL HEALTH CONSULT SCREENING INFORMATION <12yrs old

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

Who referred you for treatment: _____

Presenting Concerns: _____

_____

When did symptoms first start? _____

Primary Care Physician (PCP): _____

Allergic to anything: YES NO if so list: _____

PLEASE CIRCLE ANY OF THE FOLLOWING AND FILL IN ANY BLANKS THAT APPLY

Education: Current Grade_____ Alternative School Placement Home Schooled Special Education

GED Pre-AP/AP/IB classes 504 Plan/IEP Learning Disorder Advanced/Gifted Grade Failures ____

School behavior problems Social Anxiety Inattention/Unfocused Bullied/Teased Aggressive/bully

Frequent suspensions/ISS Reasons for suspensions:_____

Home Environment

Parent's marital status: Married Never Married Divorced Widowed Remarried Single

Adopted: Details_____

Foster Parent: Details_____

Name of Household Members:

Name: Age Relationship

1)

2)

3)

4)

5)

Home type: Apartment Mobile House Homeless Duplex Hotel/Motel Lives with friends/family

Years in home: _____ Number of moves in the last 5 years: _____

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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 Weight gain/loss

Thoughts of hurting self Cutting/Self-harm Moodiness Excessively tired

Negative self talk Low self-esteem

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

Sleeps w/caregiver Hours slept per night_____ Afraid of dark Wanders at night

Sleep walks

Anxiety:

None Anxious Worries A Lot Panic Attacks Trouble leaving home

Seperation Anxiety Phobias Social Anxiety

Post-Traumatic Stress Symptoms:

None Flashbacks Nightmares Startle Response Phobias

Guilt Withdrawing Spacing out Sleep Disturbance Irritability

Feeling Numb Panic Attacks Social Withdraw

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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):_____	

Was abuse reported to police, hotline, or CPS? Yes No

If yes, when?_____

Is the case still open? _____

Impulsivity and hyperactivity:

Impulsive/hyperactive	Often interrupts	Difficulty waiting turn	Blurts out answers
Restless	Talks Excessively	Fidgets and Squirms	Excitable
On the go	Destructive		

Attention and Concentration:

Alert Focused Easily Distracted Disorganized Errors Preoccupied

Forgetful Careless Mistakes

Oppositional Behaviors:

Biting	Head Banging	Physical Aggression	Tantrums	Verbal Aggression
Yelling	Oppositional to Adults	Defiant	Spiteful	Disrespectful
Bully to Others	Drug Use	Sneaking out	Run Away	Lying

Manipulative Disregard for safety of self/others Extreme sibling/parent/teacher/peer conflict

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Substance Abuse:

None Alcohol Marijuana Sedatives Nicotine Synthetic Marijuana/Bath Salts

Other: _____

Treatment received: _____

Family History of Substance Abuse:

Mother Father Sibling Stepparents Grandparents Aunts Uncles

Family Psychiatric History:

None Unknown Depression Anxiety PTSD ADHD Schizophrenia Obsessive-compulsive

Eating Disorder Bipolar Disorder Personality Disorder History of Sexual Abuse/Assault

History of Physical Abuse/Domestic Violence Suicidal Idation/Attempts/Completion

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: _____

PLEASE CIRCLE ANY OF THE FOLLOWING AND FILL IN ANY BLANKS THAT APPLY

Birth History:

Unknown Birth Weight ____lbs____oz Full term Premature C-Section

Drug/Alcohol use during pregnancy Placed in foster care Adopted Emotional Stress during pregnancy

Complications during pregnancy:_____

Birth Order _____ of _____.

Surgeries or Medical Issues:_____

Developmental History:

Unknown No Concerns Reported Chronic/Multiple Illness

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Speech/Language Delay | Multiple Injuries | Feeding Problems

"Difficult Child" | Colic | Late Walker

Developmental Delays | Head Injury | Bladder/Bowel Control Problems

Medical History/Conditions:

Head Injury | Diabetes | Asthma | Headaches

Anemia | Tumors/Cancer | Heart Trouble | Bedwetting/Soiling Issues

Chronic Fatigue | Dizziness/Fainting | Kidney Disease | High Blood Pressure

Speech/Language/Hearing Issues | Seizures

Other Medical Conditions or Surgeries: _____

Nutritional Screening:

Normal | Appetite Disturbance | Food Allergies_____ | Eating Issues

Food Hoarding | Overweight | Underweight | Chewing/Swallowing

Pain and Comfort:

No Current Pain | Current Physical Pain | Chronic Pain: Constant | Sharp | Dull | Burning

Stabbing | Takes Pain Medication | Has had Surgery | Completed Physical Therapy

Sexuality

Sexually Active | Not sexually active

Heterosexual | Homosexual | Bisexual | Pansexual

Sexual Abuse | High risk sexual behavior | Sexual Identity Concerns | Gender Identity Concerns

HIV | History of STD's

Leisure Activities/Hobbies: _____

What changes would you like to see with treatment? _____

_____

What is your goal for your child? _____

_____

What will successful treatment look like to you? _____

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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