QUALITY BEHAVIORAL HEALTH, INC.

PATIENT INTERVIEW SHEET

DATE: _____

Patient Name: _____ Date of Birth:_____ SSN:_____
Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone:_____ Cell:_____
Sex: Male Female Age: _____ Marital Status: S M D W OTHER
Pharmacy Phone Number:_____

May I (or my billing service) contact you at work? Yes____ No___

Occupation: _____ Employed by: _____
Referred By: _____
Primary Physician: _____
Address: _____ Phone #: _____

FAMILY INFORMATION

Person to notify in case of an emergency:_____Phone: _____

If the patient is under 18 years of age:
Father's Name: _____ Mother's Name: _____

INSURANCE INFORMATION

Primary Insurance coverage: _____ Type: PPO POS HMO
Policy Number: _____ Group Number: _____
Policy Holder's Name: _____ Relationship: _____
Insured's date of birth: _____ Phone # on back of card: _____

Secondary Insurance coverage: _____ Type: PPO POS HMO
Policy Number: _____Group Number:_____
Policy Holder's Name: _____ Relationship: _____
Insured's date of birth: _____ Phone # on back of card: _____

All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment.

I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authorize Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federal law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that this office has received regarding your medical history and billing records given reasonable advance notice. Please inform us if you have nay concerns regarding your privacy, billing records or any other information.

SIGNATURE: _____DATE: _____

QUESTIONNAIRE I

INSTRUCTIONS: Please circle every word or phrase which describes how you have been feeling in the last four (4) weeks.

NAME: _____ AGE: _____ DATE: _____

ENERGY LEVEL
Tired
Restless
Increase Energy
Decrease Energy

MEDICAL SYMPTOMS
Constipation
Diarrhea
Abdominal Pain
Chronic Pain
Headaches
Increased Weight
Increased Appetite
Decreased Appetite
Panic Attacks

SLEEP HABITS
Difficulty Falling Asleep
Waking Up During Night
Consistent Nightmares
Increased Sleep
Decreased Sleep

BEHAVIORAL SYMPTOMS
Violent Behavior
Financial Problems
Parenting Problems
Abuse of any Type

OUTLOOK
Poor Concentration
Poor Memory
Pessimistic
Helplessness

MOOD
Sad
Gloomy
Anxious
Lonely/Isolated
Feeling Hopeless
Mood Swings
Irritable
Feeling Worthless
Lack of enthusiasm
Cry for no reason
Guilty
Cries Daily
Cries Easily

SOCIAL AND PERSONAL SYMPTOMS
Decrease Sex Drive
Increase Sex Drive
Upset by little things
Difficulty enjoying things
Impaired Social Skills
Impaired Vocational Skills
Lack of Interest in Hobbies/Activities
Thoughts of suicide
Attempted Suicide
Cutting/Picking
Thoughts of Hurting Self
Thoughts of Hurting Others
Thoughts of destroying property
Have you destroyed property
Plan to Hurt Self
Plan to Hurt Others

ALCOHOL OR DRUG USE:

How Often?_____ How Much?_____

Drink or Drug of Choice?_____

Have you ever felt the need to cut down on your drinking or drug use?_____
Have you ever felt annoyed by criticism of your drinking or drug use?_____
Have you ever had guilty feelings about your drinking or drug use?_____
Have you ever taken a morning eye opener?_____
Have you ever missed work/school due to your drinking or drug use?_____

_____ _____

Clinician Signature Date

STATEMENT OF PATIENTS' RIGHTS

AS A PATIENT YOU HAVE THE RIGHT:

- To be informed in the language that you understand
- To be informed about what to expect during the treatment process.
- To be informed of the cost of services rendered to you and to your family as soon as the information is available.
- To know the benefits, risks, and side effects of all medications and treatment procedures that may be prescribed for you and to be apprised of alternate procedures.
- To refuse treatment or any procedures or specific medication that are unusual, hazardous, and/or experimental.
- To have competent, qualified, experienced clinical staff to supervise and carry out your treatment
- To be referred to an alternate treatment setting if you are inappropriate or ineligible for treatment at the present level of care.
- To expect confidentiality and your privacy respected from the entire staff with respect to your identity, diagnosis, prognosis, and treatment
- To be encouraged and assisted throughout your treatment to understand and exercise your rights as a client without fear of restraint, interference, discrimination, or reprisal.

YOU HAVE TO RIGHT TO KNOW:

- The name and specialty of any of the professionals responsible for your care.
- Any rules and regulations of the facility which apply to your behavior as a patient.
- No client shall be requested to perform services for the facility which are not stated as part of your program treatment plan
- No client shall be allowed to perform services in lieu of treatment fees.
- There shall be evidence that the facility has a mechanism for allowing the client and/or legal guardian to present suggestions or grievances.

YOU HAVE THE RIGHT:

To file a complaint with:

Executive Director
Quality Behavioral Health, Inc.
75 Lambert Lind Highway
Warwick, RI 02886

In accordance with Title VI of the Civil Rights Act of 1964 (42 USC S2000d et. esq.); 45 CFR Part 80, Section 504 of the Rehabilitation Act of 1973, as amended; (28 USC S794); 45 CFR Part 84, Age Discrimination Act of 1975, as amended, 45 CFR Part 91, Quality Behavioral Health does not discriminate on the basis of race, religion, sex, sexual orientation, color, national origin, handicap, or age in admission or access to treatment or employment in its programs or activities.

I have read and understand all of my rights as a patient.

_____ _____

SIGNATURE DATE

QUALITY BEHAVIORAL HEALTH, INC.
75 Lambert Lind Highway
Warwick, RI 02886

NOTICE OF PRIVACY PRACTICES

This notice describes how medial information about you may be used and disclosed and how you may have access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by Quality Behavioral Health, Inc. , in any form, whether electronically, on paper, or orally, be kept confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. "HIPAA" provides penalties for individuals or companies that misuse personal health information.

As required by "HIPAA", Quality Behavioral Health, Inc., has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may disclose Protected **Health Information (PHI)** to doctors, nurses, technicians or other personnel outside of this office who are involved in your medical care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may share PHI with your health insurance to receive payment for health care services we provide to you. We may also share PHI with billing companies and companies that process our health care claims.

- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and patient quality of care.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your PHI, which you may exercise by presenting a written request to the Office Manager.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or an other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Continued on Back

- The right to reasonable requests to receive confidential communications of PHI information from us by alternative locations.

- The right to inspect and copy your PHI. This must be requested in writing and we will respond to to this request within 30 days. If you request a copy of your PHI, a fee will be charged for which you will be notified in advance.

- The right to amend your PHI. If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include a reason for the request. **We will respond within 60 days of your request. We may deny your request if the PHI is 1) correct and complete, 2) not created by this office 3) not allowed to be shared with you, or 4) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.** If we agree to honor your request, we will change your PHI, informs you of the change, and informs any other health care providers involved in your care of the change to your PHI.

- The right to a paper copy of this notice from Quality Behavioral Health, Inc.

We are required by law to maintain the privacy of your protected health information and to provide you with notice our legal duties and privacy practices with respect to PHI.

This notice is effective October 23, 2008, and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of P privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201 and about violations of the provisions of this notice or the policies and procedures of our office. Your complaint will not alter or affect the quality of care that we provide to you.

QUALITY BEHAVIORAL HEALTH, INC.
75 Lambert Lind Highway
Warwick, RI 02886

NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of Quality Behavioral Health, Inc.'s Notice of Privacy Practices.

_____ _____
Signature Date

_____
Signature of Legal Guardian

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____
Date Staff Initials Reason

Quality Behavioral Health

75 Lambert Lind Highway
Warwick, RI 02886

COMMITMENT TO CUSTOMIZED, INTEGRATED, QUALITY CARE

The mission of Quality Behavioral Health is to provide you and your family with assistance and guidance during periods of transition and distress. At Quality Behavioral Health our evidence-based treatment model emphasizes the importance of understanding human health and the basis for human behavior and mental illness. This approach includes the integration of biological, psychological, and social factors that are influential in the assessment, diagnosis, and treatment of behavioral disorders. Both pharmacological and psychotherapeutic methods are employed.

Practice Guideline

Your first visit at Quality Behavioral Health will be an assessment conducted by a licensed psychotherapist. The assessment will gather information for the therapist and psychiatrist to make an accurate diagnosis.

Treatment may or may not include medication. However, if medication management is indicated by a staff psychiatrist it will also be required that you receive counseling during the period of treatment. Frequency of appointments will be determined by the patient and therapist.

RULES OF PRACTICE

- 24 hours notice is required if an appointment is to be cancelled
- You will be discharged from the practice for a second missed appointment for either a no-show or late cancellation with a Psychiatrist or Therapist
- Should you be discharged a list of referrals to other providers of services will be made available
- Upon discharge you will be provided with a 30 day supply of medications if appropriate. You will be expected to make a follow-up appointment elsewhere. No further refills will be provided beyond the 30 day supply.
- Transfer of records can be made available upon written request

Signature: _____ **Date:** _____

Quality Behavioral Health, Inc.

AUTHORITY FOR MEDICAL TREATMENT FOR RESIDENTIAL PROGRAMS

Youth:_____SS#:_____Program:_____

I,_____(print name), as the parent/guardian of the above named minor child, appoint Quality Behavioral Health, Inc. (QBH) as my representative for the purposes set out in this document. I authorize QBH to provider or seek the following kinds of treatment for my child.

This Authority Covers

1. Representatives of QBH have the authority to seek emergency diagnostic testing and medical treatment including surgical care and hospitalization for my child in the event of a medical, dental, substance abuse or mental health emergency.
2. Representative of QBH have the authority to seek diagnostic testing and treatment for non-emergency, routine, and preventative medical, obstetrical, gynecological, dental, substance abuse and mental health issues for my child.
3. Representatives of QBH may obtain medical information and health history from my child's healthcare providers in order to provide appropriate healthcare.
4. Representatives of QBH may release medical information and health history to healthcare providers treating my child in order to provide appropriate healthcare.
5. Representatives of QBH are authorized to provide first aid for the treatment of injuries and illnesses as designated in Standing Orders.
6. Representatives of QBH may administer medications prescribed for my child when the medications are obtained from a pharmacy or brought to the program in original pharmacy bottles.
7. Representatives of QBH may administer non-prescription medications for illnesses or injuries as designated in Standing Orders.
8. Representatives of QBH have the authority to obtain and administer immunizations and screening tests for tuberculosis for my child as needed.

I understand that it is my responsibility to notify QBH of any medical, dental, substance abuse or mental health condition, such as allergy, physical or mental disability that my affect my child's participation in this program.

I understand that I am responsible for my child's healthcare during home visits.

I understand that a representative of QBH will contact me as soon as possible in the event of a serious medical emergency/injury but will not delay treatment prior to my notification of the emergency.

I understand that a representative from QBH will notify me via phone or in writing of any health related treatment provided off-site and any change, discontinuation or addition of a medication unless notification breaches client confidentiality.

I declare that I have read and understand the terms of this authority. All questions I have concerning the powers I have given QBH in this document have been answered to my satisfaction.

Dated this_____day of_____,20___.

_____

Parent or Legal Guardian (Signature) Phone

_____

Address

STATE OF_____ COUNTY OF_____

_____Has sworn and subscribed before me and is personally known

_____or has produced identification_____on this_____day of_____,20_____.

Notary Public_____