Participant Information

Name ______________________________________ Preferred Name ______________________________

Gender at Birth _____________________ Gender Identity______________________

Address ____ City ________________ State ____ Zip ______

Home/Cell Phone ________________________________ Work Phone __________________________

Birth date _________________Age________ SSN __________________Marital Status ______________

Do you want to ☐ Private Pay ☐ Use Insurance Benefits listed below

Insurance Type ☐ Commercial ☐ Centennial ☐ EAP

Primary Insurance Provider _____________________ Insurance ID # ___________________________

Primary Insured Name _____________________________ Primary Insured DOB: _________________

Primary Insured SSN ______________________ Secondary Insurance Provider ____________________

Secondary Insurance ID # ___________________ Secondary Insured Name _______________________

Secondary Insured DOB _________________ Secondary Insured SSN __________________________

Are you presently under a physician's care? YES NO

If yes, for what? ____

Physician's name _____________________________ Psychiatrist's name__________________________

Were you referred to this agency? YES NO

If yes, by whom____

Do you have a Psychiatric Advance Directive (PAD)? YES NO

If yes would you be willing to provide us a copy for your record? YES NO

If No, would you like us to provide you information on a PAD? YES NO

Medication (s) and dosage (current)

____

____

Have you received prior counseling? YES NO

If yes, was it: OUTPATIENT INPATIENT

When _________________________________ Where __________________________________

By whom _______________________________ Length of treatment

____

Problem(s) treated

____

Outcome: ☐ Very Successful ☐ Somewhat Successful ☐ Stayed the same ☐ Somewhat Worse ☐ Much Worse

Form Completed By: ____

Emergency Contact:

Name ____ Relationship __________________

Address ____

Home/Cell Phone ________________________________ Work Phone ____________________

Please check any of reasons listed below which resulted in you seeking services

- ❍ Depression
- ❍ Anxiety
- ❍ Issues w/partner
- ❍ Communication Difficulties
- ❍ Relationship enhancement
- ❍ Parent/Child conflict
- ❍ Identity issues
- ❍ Court-ordered for: __________
- ❍ Gambling
- ❍ Personal Growth
- ❍ Medical: __________________
- ❍ Alcohol or substance use
- ❍ Difficulty with loss or death
- ❍ Problems at school/work
- ❍ Issues w/Family
- ❍ Trauma/Abuse
- ❍ Child Behavior/Acting Out
- ❍ Divorce
- ❍ Legal problems
- ❍ Parenting
- ❍ Skills Acquisition
- ❍ Other: ________________________

Please provide a summary of why you are seeking therapy in the space below.

THE FAMILY® CONNECTION
CHANGING MENTAL HEALTH

As you think about the primary reason that brings you here, how would you rate its frequency and your over-all level of concern at this point in time (note: a problem may occur rarely but be of serious concern, or occur frequently, but be of little concern)?

Concern	Frequency
❍ No concern	❍ No occurrence
❍ Little concern	❍ Occurs rarely
❍ Moderate concern	❍ Occurs sometimes
❍ Serious concern	❍ Occurs frequently
❍ Very serious concern	❍ Occurs nearly always

On a scale of 0 to 10, how **IMPORTANT** is it for you right now to change?

Not confident at all 0____1____2____3____4____5____6____7____8____9____10 Extremely Confident

On a scale of 0 to 10, how **CONFIDENT** are you that you could make this change?

Not confident at all 0____1____2____3____4____5____6____7____8____9____10 Extremely Confident

On a scale of 0 to 10, how **READY** are you to make this change?

Not confident at all 0____1____2____3____4____5____6____7____8____9____10 Extremely Confident

This form has been completed to the best of my abilities and I attest that the information contained herein in accurate.

X ________________________ Client/Parent/Guardian Signature

________________ Date

Patient Name ____ **DOB** __________________

Clients' Rights and Responsibilities

- You have a **right** to receive information about The Family Connection, LLC services, therapists, treatment guidelines and your rights and responsibilities.
- You have a **right** to be treated with dignity and respect.
- You have a **right** to privacy and confidentiality. I understand that during couples session's confidentiality goes to the couple unit.
- You have a **right** to participate with your therapist in making decisions about your treatment planning.
- You have a **right** to access supports outside of your counseling appointments, such as the use of 911 in emergencies or the 24/7 NM Crisis & Access Line at 1-855-662-7474, a free and confidential support service
- You have a **right** to voice complaints about The Family Connection and/or the care provided to you.
- You have a **righ**t to make recommendations regarding these "Clients' Rights and Responsibilities".
- You have a **responsibility** to provide, to the extent possible, information that The Family Connection, LLC and its therapists need in order to care for you.
- You have a **responsibility** to follow the plans and instructions that you have agreed upon with your therapist.
- You have a **responsibility** to participate, as much as possible, in understanding your behavioral health problems and developing mutually agreed-upon treatment goals.
- You have a **responsibility** to cancel your appointments with a minimum of 24-hour notice.
- You have a **responsibility** to notify and work with your therapist regarding any concerns of safety to yourself or others, including following through on agreed upon safety contracts.

Signature____ Date________________

Signature____ Date________________

Behavioral Health Release of Medical Information for Care Coordination with PCP

Patient Name: ______________________________________ DOB: ___________________

Parent/Legal Guardian Name (if applicable):_______________ Relationship to patient: ________

The current health care system is complicated. When patients get care, they may interact with any number of providers across multiple settings and if health care providers don't coordinate with each other, the consequences can be harmful to the patient. As a community provider we aspire to ensure that you get the best quality care, which includes providing you the opportunity to allow your care to be coordinated with your primary care provider. Please complete the form below to advise us what information, if any, you would like shared with your primary care provider.

❑ **I DO NOT authorize** information about my physical/behavioral health treatment to be released

❑ **I authorize** The Family Connection, LLC to use and disclose the protected health information as indicated below:

- All health records related to drug/alcohol/substance abuse
- All health records related to emotional/mental/developmental disabilities/psychiatric conditions **(excludes psychotherapy notes)**
- Other: ____

Release of medical information from/to The Family Connection LLC to/from my:

Primary Care Physician: _______________________________________
Address: ____
Phone: ________________________ Fax: __________________________

I understand that this medical information may be used to coordinate my care.
I understand that I may cancel this authorization, in writing, at any time. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation. I understand that this will remain in effect until the end of treatment unless a date of expiration is indicated here: ______________

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ___________

Signature of patient or personal representative **Date**

Symptom Distress Scale

During the last seven (7) days, about how much were you distressed or bothered by:

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
a. Nervousness or shakiness inside............................	1	2	3	4	5
b. Being suddenly scared for no reason...................	1	2	3	4	5
c. Feeling fearful...	1	2	3	4	5
d. Feeling tense or keyed up....................................	1	2	3	4	5
e. Spells of terror of panic..	1	2	3	4	5
f. Feeling so restless you couldn’t sit still.................	1	2	3	4	5
g. Heavy feeling in arms or legs...............................	1	2	3	4	5
h. Feeling afraid to go out of your home alone.........	1	2	3	4	5
i. Feeling worthless..	1	2	3	4	5
j. Feeling lonely even when you are with people…	1	2	3	4	5
k. Feeling weak in parts of your body.......................	1	2	3	4	5
l. Feeling blue..	1	2	3	4	5
m. Feeling lonely...	1	2	3	4	5
n. Feeling no interest in things..................................	1	2	3	4	5
o. Feeling afraid in open spaces or on the street……	1	2	3	4	5
ADD ALL					
				TOTAL (min: 15, max:	

Client Name DOB SS# Date

Scored By Title Date Scored

For Office Use Only:
Scoring: Items rated 3 or higher are considered to indicate serious distress. A total summed score of 25 or above indicated moderate distress; Scores of 33 or above indicate severe distress that requires immediate intervention.

TFC.Health
(505)717-1155

Name:	DOB:

Adult Depression Screening Form

Zung Depression Self-Rating Scale ©

INSTRUCTIONS: Please fill in one response for each of the 20 statements below based upon how you have been feeling over the past two weeks or longer. Then, please respond to the free-standing statement after item 20.

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time	Item Rating
1. I feel downhearted, blue, and sad.	❍ 1	❍ 2	❍ 3	❍ 4	
2. Morning is when I feel best.	❍ 4	❍ 3	❍ 2	❍ 1	
3. I have crying spells or feel like it.	❍ 1	❍ 2	❍ 3	❍ 4	
4. I have trouble sleeping through the night.	❍ 1	❍ 2	❍ 3	❍ 4	
5. I eat as much as I used to.	❍ 4	❍ 3	❍ 2	❍ 1	
6. I enjoy looking at, talking to, and being with attractive women/men.	❍ 4	❍ 3	❍ 2	❍ 1	
7. I notice that I am losing weight.	❍ 1	❍ 2	❍ 3	❍ 4	
8. I have trouble with constipation.	❍ 1	❍ 2	❍ 3	❍ 4	
9. My heart beats faster than usual.	❍ 1	❍ 2	❍ 3	❍ 4	
10. I get tired for no reason.	❍ 1	❍ 2	❍ 3	❍ 4	
11. My mind is as clear as it used to be.	❍ 4	❍ 3	❍ 2	❍ 1	
12. I find it easy to do the things I used to do.	❍ 4	❍ 3	❍ 2	❍ 1	
13. I am restless and can't keep still.	❍ 1	❍ 2	❍ 3	❍ 4	
14. I feel hopeful about the future.	❍ 4	❍ 3	❍ 2	❍ 1	
15. I am more irritable than usual.	❍ 1	❍ 2	❍ 3	❍ 4	
16. I find it easy to make decisions.	❍ 4	❍ 3	❍ 2	❍ 1	
17. I feel that I am useful and needed.	❍ 4	❍ 3	❍ 2	❍ 1	
18. My life is pretty full.	❍ 4	❍ 3	❍ 2	❍ 1	
19. I feel that others would be better off if I were dead.	❍ 1	❍ 2	❍ 3	❍ 4	
20. I still enjoy the things I used to do.	❍ 4	❍ 3	❍ 2	❍ 1	
				RAW SCORE	
				SDS INDEX	

© WWK Zung, 1965, 1974, 1989, 1991. All rights reserved.

Patient Signature

	None or a Little of the Time	Some of the Time	Good Part of the Time	Most or All of the Time
I have recently thought of, or am currently thinking of, suicide.	❍	❍	❍	❍

TFC.Health
(505) 717-1155

Informed Consent for Telehealth Services

Definition of Telehealth
Telehealth involves the use of electronic communications to enable The Family Connection LLC to connect with individuals using interactive audio, video, telephone and/or other audio/video communications.

Telehealth includes the practice of psychological health care delivery services such as assessments, diagnosis, consultation, transfer of medical and clinical data, psychoeducation, referral to resources, and treatment.

Considerations regarding Telehealth Services:

1) **Technology**

Comfort with technology varies among people and therefore, use of telemental health or "telehealth" requires a comfort and proficiency with technology. Your therapist will work to assess with you whether you might be a fit for telemental health prior to engaging in services.

As a standard of practice, we will request that you have an external wide-angle camera that allows for us to see your entire body to help us increase the efficacy of your treatment. We will also request that your internet access meet the minimum standards of 15 Mbps download and 5 Mbps upload.

I understand that there are various technology platforms available for Telehealth. The Family Connection uses Doxy and WeCounsel. The goal of these platforms is to provide access to care in a convenient and accessible way that allows you to focus on your mental healthcare needs. However, it is not without risk, as any Platforms used is not 100% secure and may have issues with wi-fi connectivity. Your provider will work with you to develop a back-up plan, which will include identifying alternate treatment methods if the original platform is not performing adequately or if internet services are down, which may include switching platforms used or scheduling an in-person meeting instead. I acknowledge and agree to follow the back-up plan outlined with your therapist to mitigate technology issues, understanding that there is no guarantee of services at the specific date and time when issues with the technology cannot be resolved.

2) **Benefits and Risks**

Because of recent advances in communication technology, the field of telehealth has evolved. What is important here is that you are aware that telehealth therapy may or may not be as effective as in-person therapy and therefore, we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy. As a standard of practice and to ensure that you are receiving the highest quality of care, The Family Connection LLC requires that a minimum of one session take place in person to complete a full assessment and ensure that telehealth is a viable option for health care delivery services for you as the patient. I understand that during the course of my services, if my therapist, at any time, believes that I

would be better served by another form of intervention (e.g. face-to-face services), I will be referred to in-person counseling and/or referred to a mental health professional who can provide those services in my area. I acknowledge that there is no guarantee that telehealth sessions will eliminate the need for me to see a therapist or other mental health provider in person.

I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of various technology platforms such as Doxy, WeCounsel, Zoom, etc. are not 100% secure and may have issues with WIFI connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with these communication platforms.

I understand that the alternatives to counseling through telehealth as they have been explained to me, and I am choosing to participate using telehealth technology.

3) Scheduling

I understand that scheduling is based on my therapist's normal clinic hours. I understand that the telehealth appointment is time set aside specifically for my care and therefore, late cancellations and/or no call no shows may be assessed the entire session fee. I acknowledge that parameters for interaction with my therapist, including anticipated response times are covered in The Family Connection's Electronic Communication Consent and Social Media Policy.

4) Financial Obligations

The Family Connection LLC will bill your available insurance for telehealth services.

If insurance is not available, fees associated with telehealth appointments are payable by credit or debit card only. If fees may be associated with my telehealth services, I agree to have my credit/debit card information on file with The Family Connection LLC. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, The Family Connection LLC will cancel my appointment and I will be charged in accordance with the cancellation policy.

5) Confidentiality

The laws that protect confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my treatment is generally confidential with exceptions for safety and legal implications, as expressed in the Informed Consent document. The Family Connection agrees to use a HIPAA compliant electronic platform with a Business Associates Agreement to protect your privacy and confidentiality.

I understand that there are risks and consequences associated with telehealth including but not limited to the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my medical information could be disrupted or distorted by technical failures.

6) Receipt of Services

With telehealth, there is the question of where is therapy occurring – at the therapist's office or the location of the client? It is The Family Connection's policy to inform clients that they are receiving services as if they are in our physical office and therefore are bound by the laws of the State of New Mexico. In addition, due to our therapists' licensure, clients must reside within the State of New Mexico for all treatment services. In participating in telehealth services by The Family Connection, I agree to remain within the State of New Mexico (or for Active Duty military to remain on United States soil) during the course of the treatment session.

7) Handling Emergencies

I understand that by signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based therapy services. If I am in crisis or in an emergency, such as having thoughts about hurting myself or others, having uncontrolled psychotic symptoms, or am in a life threatening or emergency situation, and/or if I abuse drugs or alcohol or am not safe, I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. My therapist and I have discussed my options in regards to handling potential emergency situations that might arise just prior to or during telehealth services, where I have agreed to follow our emergency plan, including the use of a code word when confidentiality is no longer upheld, such as someone entering the space where you are communicating in.

CONSENT TO THE USE OF TELEHEALTH

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

If Client is a minor:

By:______________________

____
(relationship to minor)

Date:____________________

Client:

____

____
(printed name)

Date:______________________

COVID-19 In-Office Appointment Client Informed Consent and Waiver

This document contains important information about the decision to resume in-person services considering the public health crisis caused by COVID-19. Please read this agreement carefully and let your provider know if you have any questions.

DECISION TO MEET FACE TO FACE

Thank you for your trust in our practice. **By signing this consent form you are agreeing to meet in person for all or some future sessions**. Given the benefits, and inherent risks, of conducting in-person services while COVID-19 remains an active contagion in our society, we wish to address the ways in which we are working to mitigate risk of infection at our offices. We strive to protect you and our staff via hygiene and infection control practices informed by the CDC, EPA, OSHA, WHO, and other guiding organizations. We also ask that you engage in infection control practices to contribute to the health and safety of in-person services, and that **you recognize that you are voluntarily choosing to seek in-person services with knowledge of the inherent risks of infection.** If there is a resurgence of the COVID-19 virus or if other health concerns arise, we may require a return to Teletherapy appointments for everyone's well-being. In addition, at any time, you may speak to your provider if you wish to return to Teletherapy appointments.

OUR PLAN FOR OFFICE SAFETY

The Family Connection LLC takes the health and safety of our clients and staff members very seriously, and we strive to provide excellent clinical services in the safest possible environment by taking the following measures:

- Clients who are ill will be asked not to come into our offices. Staff members who show any symptoms of a contagious illness, or who have been in contact with those showing symptoms of COVID-19, or testing positive for COVID-19, will be required to stay home.
- Pre-Screening: On arrival, clients will complete a brief screening to ensure they are symptom-free and have not had close contact with anyone with COVID-19 symptoms.
- Hygiene Practices: Our staff will be practicing infection control hygiene practices, including covering coughs and sneezes, frequent hand washing, and refraining from handshakes.
- Masks: Our building management requires that all people entering the building wear a mask. Our staff will wear masks in common areas.
- Waiting Room: We will be asking parents or those coming with clients not to wait in our waiting rooms.
- Shared Items: We have removed commonly touched items to help minimize transmission of the virus, such as magazines in the waiting room.
- During Sessions: To minimize virus transmission in session, seating will be arranged to facilitate social distancing of at least six feet where possible; utilization of air purifiers; windows can be opened for air ventilation; and each office and waiting room will be equipped with hand-sanitizer, sanitizing wipes, facial tissue, and trash cans for disposal.

- Frequent Sanitizing: Common areas and equipment, such as door knobs, will be sanitized throughout the day, offices will be sanitized between sessions, and therapy and testing materials (e.g,. chairs, tables, waiting room, toys, desks) will be sanitized between use, per CDC guidelines.
- Scheduling: We will be staggering staff schedules where needed to minimize crowding in the office. We ask for your understanding and flexibility if your usual appointment time is impacted by these schedule changes.

YOUR RESPONSIBILITY FOR PROTECTING YOURSELF AND OTHERS

If you, a family member, or anyone that you have been in contact with in the past 14 days have had symptoms of COVID-19, including fever/chills, coughing, shortness of breath, muscle pain, and/or sore throat, OR tests positive for COVID-19, please do not plan to come into the office . We ask that you take your/your child's temperature at home prior to coming into the office. Anyone with a temperature above normal are asked to reschedule your appointment or change to a Teletherapy session.

- Minimizing Crowding in Waiting Rooms: In order to minimize the number of people and prevent crowding in our waiting rooms we ask that you enter the office at the time of your appointment and not before. Should you arrive early please wait in your car until the time of your appointment. Please come to appointments alone. In the case of young children, please have only one parent or family member accompany them to the office then, when possible, wait in the car until the session is complete. Please do not linger after appointments in our waiting rooms or the hallways.
- Masks: Our building requires anyone entering the building at this time to wear a mask. This applies to all clients and family members who might accompany them to appointments. **Please keep masks on in the waiting rooms and all common areas.**
- Hygiene: You are encouraged to use bathrooms to wash hands upon arriving for your appointment, hand sanitizer will be available in all rooms, and we ask that clients refrain from touching faces, and maintain social distancing, where possible.

IDENTIFICATION AND NOTIFICATION OF EXPOSURE TO COVID-19

Although we are making every reasonable effort to manage infection risk, and believe that most clients are doing the same, we recognize that some individuals with the virus remain asymptomatic and that there is no way to guarantee that those entering our offices will not be exposed to COVID-19. For public health protection, *we ask that any client who has been in our offices and subsequently experiences symptoms of COVID-19, or has been exposed to another person with symptoms of COVID-19, please* ***notify our office immediately*** *so that we can take any additional infection control measures and notify others who have been exposed*.

Should we learn that any staff member, client, or household member of anyone who has been in our office has symptoms of COVID-19 or tests positive for the COVID-19 virus, **we will notify all individuals who have been in our office in the same time frame of the potential that they may have been exposed.** Notifications will be provided to those who had been in our offices and may have come into close contact on the day that the infected individual was also in that office.

We will not disclose names or the role of the person infected (e.g., client, janitorial staff, therapist) in an effort to protect confidentiality and privacy.

COVID-19 PROTOCOL COORDINATOR

Kelly St Germain, Executive Assistant, is our COVID-19 Office Protocol Coordinator. She is the contact person to address any questions or concerns and can be reached at (505) 717-1155 ext.125 or kelly@nmfamilyconnection.com. Please contact Ms. St Germain immediately to report any exposure to or positive test of the COVID-19 virus.

DISCLAIMER

We realize these changes might feel strange or uncomfortable, and that the COVID-19 virus situation may change in the coming months. We encourage you to speak with your clinician if you have difficulty adjusting to the new health practices. **Teletherapy continues to be an option for you at any time if you are not comfortable coming to the office for in-person sessions.**

As you elect to return to the office for in-person appointments, we have procedures in place to mitigate risk per recommended guidelines. However, as with the transmission of any communicable illness, you can still be exposed to COVID-19 at any time. By signing below, you agree to hold The Family Connection LLC and all staff members harmless in the event that you, or anyone exposed by you, becomes ill with the COVID-19 virus.

______________________________ ______________________
Name of Client Date

____
Signature of Client or Parent/Guardian