SOCIAL HISTORY

Client Name: _____Birth Date:_____Today's Date: _____

Address: City: State: Zip: Phone:

Marital Status: Number of Children:

What is the main reason the client wants treatment?

Are there currently any problems with:

☐ Home/Family ☐ School/Work ☐ Social ☐ Environment ☐ Money ☐ Health ☐ Legal ☐ Other

How would you describe the client's behavior or personality?

_____

If the client is currently in school -

School District: School:

Grade: Classes: ☐ Regular ☐ Learning Support ☐ Emotional Support ☐ IU ☐ Other Any current problems in school?

Performance in school: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Other

Are there any cultural or religious issues which may affect treatment? ☐ Yes ☐ No

If yes, please explain. _____
_____
_____

Please list activities the client has participated in, past and present (School activities, camp, sports, etc.) Activity Dates Involved

Please list all current mental health providers (Case management, Psychiatrists, Therapists,etc.)

Please list all past mental health providers (Case management, Psychiatrists, Therapists, etc.)

Are any of the following agencies currently involved with your family?

☐ Children & Youth ☐ MHIDD ☐ Probation ☐ York Co. D &A ☐ Other

If so, please explain. _____

_____

_____

This section is to be completed only for clients UNDER 18 years of age.

Parents' Names Address Phone

_____

_____

_____

Who has legal custody of the client?

Can you make a copy of the relevant court order available to us? ☐ Yes ☐ No ☐ Received

Please understand that in most cases, BOTH parents share legal custody of minor children. If there is no court order that awards one parent sole custody, Pennsylvania law requires the consent of BOTH parents of an individual under 14 years of age in order for that individual to have a psychological evaluation for any purpose. Even if the individual has no contact with the other parent, or if the parent is not paying child support, BOTH parents must consent before that individual can be evaluated. An individual who is 14 years old or older can consent to evaluation and does not require parental consent.

1. Do you ever see your parents or other adults in your home hitting, kicking, punching, or hurting each other in some way? ☐ Yes ☐ No

2. Do you ever hear mean words or yelling/ screaming between adults in your house? ☐ Yes ☐ No 3. Have you ever been hit, kicked, punched, slapped or hurt in other ways by adults in your home? ☐ Yes ☐ No 4. Do you feel safe at home? ☐ Yes ☐ No

PERSONAL/MEDICAL HISTORY

Primary Care Physician's Name: _____ Phone: _____

Are you presently receiving medical care? ☐ Y ☐ N If yes, please explain: _____

_____

Are you allergic to any medications or environmental substances? ☐ Y ☐ N

yes, please indicate: _____

_____

Are your immunizations up to date? ☐ Y ☐ N

Have you ever used drugs other than those prescribed by a physician? ☐ Y ☐ N

If yes, type of drug: _____

Current Medications/Supplements:

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY	LAST USED

Have you, or any family member, been diagnosed with:

	SELF	MOTHER	FATHER	SIBLING	CHILDREN	Grandparent	OTHER
Anemia							
Arthritis							
Asthma							
Cancer							
Dementia							
Diabetes							
Eating Disorder							
Emphysema							
Epilepsy							
Heart Problems							
IBS							
HIV/AIDS							
Kidney Issues							
Mental Illness							
Migraines							
Substance Abuse							
Liver Problems							
Thyroid Issues							

I will be responsible for notifying BB4B of any changes in my medication or medical history.

_____ _____

Signature of Consumer or Guardian (if consumer is under 14 years old) Date

_____ _____

Witness Date

Client Name_____ DOB _____

DEVELOPMENTAL HISTORY

Please complete for all clients UNDER age 18.

Mother's health during pregnancy: Good Fair Poor Other Any illness/complications during pregnancy? (For example, Rh Negative , Toxemia, Diabetes)

Any substance abuse before or during pregnancy? (Specify)

Delivery:
Length of Pregnancy: months Labor: hours Delivery: Vaginal Caesarean Birth Weight:

Complications at birth, if any:

Child's condition at birth:

First Walked at _____months/years Difficulties: __

First Words at months/years Difficulties:

First Sentences at months/years Difficulties:

Toilet Trained at months/years Difficulties: __

Any unusual illnesses/injuries/accidents?

Child Raised by Parents? Yes No - Please Specify: _____

_____

Any child care arrangements?

Any child care difficulties?

Any long separation from primary caregiver(s)?

Any social or behavior problems? (Specify)

Describe child's temperament:

Comments:

AUDIT (Alcohol Use Disorders Identification Test

One unit of alcohol is: ½ pint average strength beer/lager OR one glass of wine OR one single measure of spirits. Note: a can of high strength beer or lager may contain 3-4 units.

1. How often do you have a drink containing alcohol? (0) Never [Skip to Questions 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0*	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
Record total of items here:	

The minimum score (for drinkers) is 0 and the maximum possible score is 30. A score of 8 is indicative of hazardous and harmful alcohol use, And possible alcohol dependence. Scores of 8-15 indicate a medium level and score of 16 and above a high level of alcohol problems.

Client Name _____ DOB _____

DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months. Carefully read each statement and decide if your answer is *"Yes"* or *"No"*. Then circle the appropriate response beside the question.

In the following statements "drug abuse" refers to:

1. the use of prescribed or over-the-counter drugs in excess of the directions,

and 2. any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These Questions Refer to the Past 12 Months			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Interpretation (Each "Yes" response = 1)

Score	***Degree of Problems Related to Drug Abuse***	***Suggested Action***
0	No Problems Reported	None At This Time
1-2	Low Level	Monitor, Reassess At A Later Date
3-5	Moderate Level	Further Investigation
6-8	Substantial Level	Intensive Assessment

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation. Used with Permission)

Assurance of Freedom of Choice

This form verifies that I have been informed and understand that I have a choice of Providers available to me.

I have been given freedom of choice in selecting available providers and realize that I may choose to receive treatment at any agency available. I am aware that I have the right to choose between at least 2 providers. If I wish, alternative Providers will be made available to me through:

York County

Community Care Behavioral Health 888-251-2224 York County MHIDD 717-771-9618 True North Counseling 717-764-4550

Lancaster County

PerformCare 888-700-7370

Lancaster Co BH and Developmental Services 717-735-8949 Team Care 717-391-0172

Signature: Date:

Witness: Date:

Client Name _____ DOB _____

Dear Client,

Psychologists and Therapists have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws, also, attempt to ensure the confidentiality of this sensitive information.

The federal government published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by psychologists, physicians, hospitals, other health care providers and health plans.

This regulation protects virtually all clients regardless of where they live or where they receive their care. Every time you see a therapist, physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, psychologist, the hospital or other health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats are protected by the Privacy Rule.

The Privacy Rule, also provides you certain rights, such as the right to have access to your Medical Records. However, there are exceptions; these rights are not absolute. We take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask your therapist or the owner(s) about exercising your rights or how your health information is protected in our office.

Please let us know if you have any questions about our Notice of Privacy Practices. You may discuss any questions you may have with your therapist.

PURPOSE:

To comply with the requirements of the privacy regulations issued under the Health Insurance Portability and Accountability Act that pertain to an individual's right to-adequate notice of the uses and disclosures that may be made of their health information by the office, of the individual's rights, and of the office's legal duties with respect to their health information.

POLICY:

The office will maintain and make available a Notice of Privacy Practices that satisfies the requirements of 45 C.F.R. 164.520.

PROCEDURES:

A. Provision of Notice: The office will make its Notice available to any person who requests it. In addition, the office will:

I. Provide access to the Notice for each of its clients no later than the date of the first service delivery to such individual after April 14,2003;

II. Have the Notice available at the site of service for individuals to request to take with them, and post the Notice in a clear and prominent location where it is reasonable to expect individuals seeking service from the office to be able to easily read.

B. Electronic Notice: The office may provide its Notice to an individual by e-mail if the individual agrees to electronic notice and such agreement has not been withdrawn by that individual. If notice is provided by e-mail and the office knows that the e-mail transmission has failed, a paper copy of the Notice must be provided to the individual.

I. Any individual who receives the office's Notice electronically continues to have the right to obtain a paper copy of that Notice from the office upon request.

C. Revision to the Notice: The Notice will reserve the office, the right to change its privacy practices at any time. The office will revise the Notice whenever there is a material change in the uses or disclosure of health information, the individual's rights, the office's legal duties, or other privacy practices stated in the Notice. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which such material change is reflected.

I. Whenever the Notice is revised, the office will make the revised Notice available upon request on or after the date of the revision and will provide the revised Notice to clients on the date of first service delivery after the date of the revisions.

The office will maintain copies of each Notice it utilizes for a period of six (6) years after the date when it was last in effect.

D. Acknowledgment: Where the Notice is provided in accordance with Paragraph A. 1. above, the person providing the Notice will use good faith efforts to have client or their personal representative sign an Acknowledgment. If the person refuses to sign an Acknowledgment, the person providing the Notice will complete the lower portion of the form.

PLEASE KEEP THIS COPY FOR YOUR RECORDS

Client Name _____ DOB _____

A Bill of Rights

Our commitment is to provide quality mental health and substance abuse services to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disabilities.

1. Right to Know

- Benefits: Individuals have the right to be provided information from the purchasing entity (such as employer or union or public purchaser) and the insurance/third party payer describing the nature and extent of their mental health and substance abuse treatment benefits. This information should include details on procedures to obtain access to services, on utilization management procedures, and on appeal rights. The information should be presented clearly in writing with language that the individual can understand.
- Professional Expertise: Individuals have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Individuals have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
- Contractual Limitations: Individuals have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between a third party payer and the treating professional that could interfere with or influence treatment recommendations. Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.
- Appeals and Grievances:

  Individuals have the right to be provided information about the procedures they can use to appeal benefit utilization decisions to the third party payer systems, to the employer or purchasing entity, and to external regulatory entities. Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating professional to that profession's regulatory board and to the professional association.

2. Confidentiality

- Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals. Individuals shall not be required to disclose confidential, privileged or other information other than: diagnosis, prognosis, type of treatment, time and length of treatment, and cost.
- Entities receiving information for the purpose of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care.
- Information technology will be used for transmission, storage, or data management only with methodologies that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold or otherwise utilized. **3. Choice** Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services. Individuals have the right to receive full information regarding the education and training of professionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional. **4. Determination of Treatment** Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the individual and his or her family as appropriate. Treatment decisions should not be made by third party payers. The individual has the right to make final decisions regarding treatment.

5. Parity Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits, and catastrophic coverage in both insurance and self-funded/self-insured health plans.

6. Discrimination Individuals who use mental health and substance abuse benefits shall not be penalized when seeking other health insurance or disability, life or any other benefit.

7. Benefit Usage The individual is entitled to the entire scope of the benefits within the benefit plan that will address his or her clinical needs. **8. Benefit Design** Whenever both federal and state law and/or regulations are applicable, the professional and all payers shall use whichever affords the individual the greatest level of protection and access.

9. Treatment Review To assure that treatment review processes are fair and valid, individuals have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials and licensure required to provide the treatment in the jurisdiction in which it will be provided. The reviewer should have no financial interest in the decision and is subject to the section on confidentiality.

10. Accountability Treating professionals may be held accountable and liable to individuals for any injury caused, by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the individual of options if payment authorization is denied. Payers and other third parties may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence or by their clinically unjustified decisions.

PLEASE KEEP THIS COPY FOR YOUR RECORDS

Client Name _____ DOB _____

Consent to Treatment

I, , have been accepted into therapy at Building Bridges for Brianna (BB4B), consent to treatment, and agree to follow the treatment plan as suggested by my therapist(s).

I understand that my treatment will consist of an evaluation and may include individual, group, or other treatment options. I agree to the treatment procedures of this program and will abide by all the rules, regulations, and guidelines as described by my therapist(s). This consent does not however, waive my civil rights and I reserve the right to decline any treatment which I believe is not in my best interest. I have been made aware of BB4B's criteria for admission, treatment, completion, and discharge and understand that I have the freedom to choose among treatment providers.

My rights and responsibilities as a patient of BB4B have been explained to me and I understand that I have the continuing right to an explanation of treatment. I further have the right to voice my dissatisfaction with my treatment to my therapist(s). If not satisfied, I may put my objections into writing and submit them to Matt Dorgan or Amber Wnek, Founders of BB4B, in order that my concerns may be addressed.

I understand that all information obtained in the course of treatment will be treated as confidential to the extent allowed by law. In order for BB4B to release information to or obtain information from another agency, therapist, or individual a signed release will be needed except in the following cases where my written authorization is not necessary:

1. When treatment information becomes part of a legal proceeding where its release is mandated by specific Pennsylvania law, court order, or subpoena.
2. In the event of a medical emergency.
3. To authorized individuals within the agency of for a program audit/evaluation 4. When the patient is a minor (under the age of 18) and report that he or she is or has been a victim of physical or sexual abuse.
5. Where reasonable cause exists for elder abuse
6. If I am a clear danger to myself or others.

Attendance

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. I understand a missed or late appointment disrupts therapy schedules that impact both myself and other clients.

1. I understand that missing three scheduled therapy appointments or three "no-shows", in a three month period may be grounds for discharge from therapy. If I must cancel the appointment due to an illness or emergency, I will contact the office as soon as possible. Family emergencies will be taken into consideration.
2. I understand that I/my child must attend at least one therapy session every 30 days. 3. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel and do not attend therapy, this may be considered a "no-show."
4. I understand that if I arrive fifteen minutes late, I may not receive therapy that day. 5. While my child is attending therapy, I may leave during their session(s). But I must leave a contact number in case of an emergency and will return 10 minutes prior to the end of the session(s).

Health

1. I understand that for the purposes of this policy, communicable diseases include, but are not limited to:

Chicken Pox	Influenza	Ringworm
Conjunctivitis	Lice	Rubella
Gastrointestinal Viruses	Measles	Salmonella
Hepatitis A	Mononucleosis	Bacteria Scabies
Hepatitis B	Mumps	Streptococcal
Impetigo	Pertussis (WhoopingCough)	Infections Tuberculosis

2. I understand if I, or my child, have a communicable disease I must leave, or cancel appointments at, BB4B for the purpose of diagnosis and treatment.
3. I understand that when a communicable disease is reported or noted in a BB4B Center, the appropriate staff will be notified.
4. I understand all information reported under this policy shall remain confidential except as appropriate for the purpose of investigation, control, or prevention of communicable disease or compliance with State law and BB4B policy.
5. I understand BB4B may require a physician's statement about my, or my child's, suitability to return to BB4B premises when such person has been suspected of or diagnosed as having a communicable disease.
6. I understand if I, or my child, have been experiencing the effects of a communicable disease within the last 24 hours I am expected to cancel my appointment and inform BB4B of my reasons.

By Signing the line below I understand and consent to all terms of service from BB4B..

I acknowledge the right to receive a copy of this form

Client's signature (or POA) MH: Parent/Guardian Date
for a minor under age 18 must sign.

_____

Relationship to Client (Required only for POA or Date
for parent/guardian)

_____

Therapist Signature Date

Client Name _____ DOB _____

Communication Consent

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996, a Federal law. The Department of Health and Human Services has developed specific regulations to protect the privacy of your health information.

It is the policy of Building Bridges for Brianna to only release confidential medical information to our patients or their authorized representatives. If we try to call you and encounter an answering machine, voice mail system or unauthorized person, we will leave a message that will be limited to the patient's name, the telephone number of our office, and a request for a return call. If the name or address is not on the recorded message from the answering machine or voice mail system, we will not leave a message.

We often call ahead as a reminder of an upcoming appointment. If we try to call as a reminder and encounter an answering machine, voice mail system or unauthorized person, we will leave a message that will be limited to the patient's name, the telephone number of our office. In order to leave a message, we need written permission to do so. Your signature below gives us permission to leave a message wherever you decide is appropriate. Please check the boxes below to tell us where we many leave messages, and where you do not want us to leave messages.

Home Telephone Yes ☐ No Phone Number _____ May we leave messages at this number? Yes ☐ No ☐

Cell phone Yes ☐ No ☐ Phone Number _____ May we leave messages at this number? Yes ☐ No ☐

Work Telephone Yes ☐ No Phone Number _____ May we leave messages at this number? Yes ☐ No ☐

Client Name (please print) DOB

_____ _____

Signature of Client or Parent/Guardian Date

2782 S. Queen St Dallastown, PA 17313 Phone: 717.600.0900

Authorization for Release of Protected Health Information

☐receive from: _____
Fax: 717.600.0910

I hereby authorize _____ to ☐disclose to: _____

the following information regarding my: ☐ Advocate/Respite services:_____ specify service dates/appointments

☐ BHRS services: _____ ☐ Outpatient services: ___30 days from time of discharge with BB4B_

□ Advocate Notes
□ Monthly Summary
□ BHRS Treatment Plan □ Discharge Summary □ Demographic Information
□ Other (please specify):

□ Outpatient Initial Assessment □ Outpatient Treatment Plan □ Psychological Evaluation □ Psychiatric Evaluation
□ Referral/Treatment Summary

_____
_____
_

The purpose for disclosing the above information is to be used for: Please check below

☐ Continuing Care ☐ Insurance ☐ Legal Matters ☐ Personal Use ☐ Other: _____

I understand that:

- ♦ I have no obligation to disclose information from my record and that I may revoke this authorization by submitting a request in writing to the, BB4B, 2782 S. Queen St Dallastown, PA 17313.
- ♦ Any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.
- ♦ Once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ♦ Certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment; HIV information; and mental health services may not be re-disclosed per PA State regulations and laws and/or Federal confidentiality rules.
- ♦ PCBH will not condition the delivery of services on signing this authorization.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check below to NOT disclose such records. Checking or not checking the box is no indication that such information exists.
Records NOT to disclose:

☐ Drug and/or alcohol use, abuse, treatment, or referrals for treatment; ☐ HIV information; ☐ Mental health services. My signature also acknowledges that I was offered a copy of this document.

Print Patient's Full Name Signature of Patient/Responsible Party Date

Patient Date of Birth Witness Signature Date This authorization shall expire at the end of the year this document was signed unless otherwise specified. This authorization shall expire at the end of the year this document was signed unless otherwise specified.