

ACCESS PACKET FOR ADULTS

Welcome and thank you for selecting us to help you meet your mental health needs. Our goal is to provide you with highest quality of care possible. The attached packet of information will allow you time to gather information prior to OPEN ACCESS that will be helpful in the evaluation.

We understand that some of these forms may be challenging, time consuming, and in places redundant. We want you to know that the more information that we have the better able we will be to assist you. Please understand that this clinic does not prescribe controlled substances. This includes the following medications: Xanax, Klonopin, Ativan, Ambien, Lunesta, Adderall, Ritalin, Vyvanse, and any other controlled substance. Any psychiatric medications you receive must come from one provider. If you have an alternate provider of psych meds, we will need a confirmation from your alternate provider that they will no longer prescribe you this class of medications.

If at any time in this process you have any questions, please contact us at 325-658-7750.

In addition to this packet, please bring the following:

- Picture ID (if you have on), If you don't, please let us know so that we can refer you to Legal Aid
- Social Security Card
- Proof of Income (if available)
- Proof of Insurance (if available)

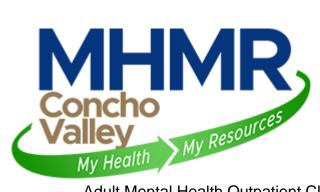
OPEN ACCESS

202 NORTH MAIN STREET

ADULT SERVICES – TUESDAYS 1:00 – 4:00 P.M.

AND WEDNESDAY 9:00 – 12:00 P.M.

We look forward to serving you.



INTAKE/ASSESSMENT
Date:
PATIENT INFORMATION
Patient Name:
List any other names you may have used in the past:
DOB: Social Security #: Gender:
Address:
(Street) (City) (State) (Zip Code)
Home Phone #: Alternate Phone #: (Area Code) (Area Code)
(Area Code)
Marital Status: Single Married Divorced Separated Widow/Widower
Place of Employment:
Are you serving in the Armed Forces or Is someone in your family a member of, or retired from, the U.S. Armed Forces?
Are you currently on Probation or Parole?
Insurance: Medicaid Medicare Private Insurance No Insurance
EMERGENCY CONTACT
Name of Emergency Contact:



Address:				
(Street)		(City)	(State)	(Zip Code)
Home Phone #:		Alternate Phone #:		
(Area Code				(Area Code)
Relationship to Patient:				
	MEDICAL and ME	NTAL HEALTH INFORM	ATION	
Primary Care Physician:				
List any allergies:				
List any medical conditions				
Is there a family history of	mental health or conce	erns?	(If yes, ple	ase explain below)
Do you have a substance u	use history? Yes	☐ No (If yes, please €	explain bel	ow)
_				
Please check any of the fol	llowing if they apply to	you at this time:		
Seeing things	Depression	Anger Outburst	s	Hearing Voices
Alcohol/Drug Abuse	Thoughts of hurt	ting yourself or someo	ne	
How were you referred to	MHMR? If so, by whom	1?		
What is the reason for you	ır visit at the clinic today	y?		



List any previous treatments for mental health issues. This includes any inpatient hospitalization, private psychiatrist, medical doctor, or other MHMR clinic. Include dates.
List all <u>current</u> medication, including psychiatric medication.



PATIENT COI	SENT FOR TELEMEDICINE SERVICES	
Name	Case #	
I have been asked by health care provider to	receive telemedicine services. The purposes is to assess and/or	

treat my psychiatric condition. This is done through at two-way audio/video link up with a health care

- 1. I, my health provider, or both of us will talk through the audio/video link with the health care provider.
- 2. If a doctor or nurse is working with me, some parts of a physical exam may be completed. I can ask that the exam and/or audio/video link be stopped at any time.
- 3. The potential risk and benefits have been discussed with me. I understand these may include (but are not limited to):

Potential Benefits

provider.

- Increased accessibility to mental health care and to specialty services.
- Convenience for me.

Potential Risks

- Information or disconnection of the audio/video link;
- A picture that is not clear enough to meet the needs of the evaluation;
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment;
- The audio/video link is conducted through the internet. There is a small chance that someone could tap into this session, if security protocols fail;
- A lack of access to all the information that might be available in an in-person visit. This could lead to errors in medical decision making.
- 4. If any of these risks occur, or if the distant site provider determines there is a reason for me not to participate, then the telemedicine service might need to be stopped. If the service is stopped for any reason, the staff at my location will work with me to develop a follow-up plan.
- 5. I authorize the release of any relevant medical information that pertains to me to the health care provider at MHMR Services for the Concho Valley. This information may include my name, age, birth date, or other information that is necessary to conduct the telemedicine services.



- 6. I understand that this service will become part of my medical record kept by MHMR Services for the Concho Valley.
- 7. I understand that I will not receive any royalties or other compensation for taking part in this service.
- 8. I understand that I must give my informed consent to participate in this service.
- 9. I acknowledge that I have received MHMR Services for the Concho Valley Notice of Privacy Practices.
- 10. I know how to contact the Texas Medical Board (1-800-201-9353) if I am seeing a doctor and have a complaint.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand its contents, and I give my consent to receive telemedicine services. This consent remains in effect unless revoked in writing.

Signature of Patient	Date
Signature of Witness	Date



		FINANCIA	AL ASSESSMENT			
Patient Information:						
Has patient been seer	here before?	Yes No)			
Patient Name:	Last Name)		(First Name)		(Middle Initi	ial)
List any other names y	ou may have us	ed in the past:				
DOB:	Social Securi	ty #:		Gender:	Male F	emale
Address:	(Street)	(City)	(State))	(Zip Code)	
Home Phone #:(Area 0		Alt	ernate Phone #:		(Area	Code)
Is patient on Probation whom?)	n or Parole?	Yes N	lo (If yes, were	you referro	ed to MHMRCV,	, if so, by
Proof of Income for at	least one month	n will need to	be provided. Die	d you brinį	g proof of Incon	ne?
Yes No	No Income	Othe	er:			
Patient is covered und	ler:					
Medicaid Me	edicare	IPs TRICA	ARE Other	:		
Name of Insurance						
ID/Policy#:						
Effective:						



Number of family members in the home
Do any of your family members living in the home receive MHMRCV Services? If so, how many
Completed by Name:
(print name)
Relationship:
Date: