Adult Behavioral Health Outpatient Clinic ♦ 202 N Main♦ San Angelo, Texas 76903

ACCESS PACKET

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)

ACCESS TO SERVICES

Simply call 325-658-7750 and ask to make an appointment for intake to services, or access services by presenting at Open Access times described below at the Adult Outpatient Clinic located at 202 North Main Street (no appointment necessary). Appointment based access to services are available Monday-Friday 8:00am – 6:00pm and on Saturdays 8:00am to 12:00pm.

OPEN ACCESS

Tuesday: 8-5
Wednesday: 8-12

Open Access operates in the capacity of walk-in services and operates as first-come, first-served opportunity. Should capacity be reached for Open Access – staff will coordinate with you an opportunity for a scheduled intake service.

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We look forward to serving you.

INTAKE/ASSESSMENT

Date: _____

PATIENT INFORMATION

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

List any other names you may have used in the past:_____

DOB: _____ Social Security #: _____ Gender: ☐ Male ☐ Female

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone #: _____ Alternate Phone #: _____
(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? □Yes □No □Veteran (If so, refer to the MVPN Unit)

Are you currently on Probation or Parole? ☐ Yes ☐ No (If yes, please list probation/parole Officer's Name below)

_____

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 MENTAL HEALTH INFORMATION

Primary Care Physician: _____

List any allergies: _____

List any medical conditions: _____

_____

Is there a family history of mental health or concerns? ☐ Yes ☐ No (If yes, please explain below)

_____

_____

Do you have a substance use history? ☐ Yes ☐ No (If yes, please explain below)

_____

_____

Please check any of the following if they apply to you at this time:

☐ Seeing things ☐ Depression ☐ Anger Outbursts ☐ Hearing Voices

☐ Alcohol/Drug Abuse ☐ Thoughts of hurting yourself or someone

How were you referred to MHMR? If so, by whom?

_____

_____

What is the reason for your visit at the clinic today?

_____

_____

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 current medication, including psychiatric medication.

PATIENT CONSENT 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 provider.

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
   - 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_____

FINANCIAL ASSESSMENT

Patient Information:

Has patient been seen here before? ☐ Yes ☐ No

Patient Name: _____
(Last Name) (First Name) (Middle Initial)

List any other names you may have used in the past: _____

DOB: _____ **Social Security #:** _____ **Gender**: ☐ Male ☐ Female

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone #: _____ **Alternate Phone #:** _____
(Area Code) *(Area Code)*

Is patient on Probation or Parole? ☐ Yes ☐ No (If yes, were you referred to MHMRCV, if so, by whom?)

_____

Proof of Income for at least one month will need to be provided. Did you bring proof of Income?

☐ Yes ☐ No ☐ No Income Other:

Patient is covered under:

☐ Medicaid ☐ Medicare ☐ CHIPs ☐ TRICARE ☐ 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: _____