



Nueva Vida Behavioral Health Associates, Inc.

E-Fax: (855) 616-0829

MEDICAL CENTER
9500 Tioga Drive
San Antonio, Texas 78230
210-616-0828

DOWNTOWN/WESTSIDE
700 S. Zarzamora
San Antonio, Texas 78207
210-375-4593

SOUTHSIDE
102 Palo Alto Rd., Suite 300
San Antonio, Texas 78211
210-922-0828

CONFIDENTIAL CLIENT INFORMATION

Please fill out the following questions as completely as possible.
PLEASE PRINT OR WRITE LEGIBLY.

Parent/Guardian:	Date:
Client Name:	Client Date of Birth:
Current Address:	Phone #:
Street:	Email:
City/State:	Social security # :
Zip Code:	
Marital/Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other :	
Nation/Tribe/Ethnicity:	Religion:
Primary language of client:	Secondary:
Referral Source:	Phone:
Emergency Contact:	Phone:

Are you here under court order for a child custody case?

Yes or No

If yes please request documents: R1 , R2 , R3 at the front desk

FAMILY RELATIONSHIPS

Do you have any children? Does Not Apply

Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information

Who else lives with you? (Include spouses, partners, siblings, parents, other relatives, friends)

Name	Age	Sex	Relationship	Additional Information

Primary language of household/family: _____ Secondary: _____

FAMILY HISTORY

Family History of (select all that apply): (X)						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Mental Illness/Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incarceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:						

(CHOOSE ALL THAT APPLY) NONE APPLY

<input type="checkbox"/> Food Stamp Recipient	<input type="checkbox"/> Protective Services (APS/CPS)
<input type="checkbox"/> ANF Recipient	<input type="checkbox"/> Court Ordered Services
<input type="checkbox"/> SSI Recipient	<input type="checkbox"/> On Probation
<input type="checkbox"/> SDI Recipient	<input type="checkbox"/> On Parole
<input type="checkbox"/> SSA (retirement) Recipient	<input type="checkbox"/> Currently pregnant
<input type="checkbox"/> Retirement Income	<input type="checkbox"/> Woman w/dependents
<input type="checkbox"/> Medicare Recipient	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Medicaid Recipient	<input type="checkbox"/> Severely Mentally Ill
<input type="checkbox"/> Homeless	<input type="checkbox"/> Developmentally Disabled
<input type="checkbox"/> Shelter Resident	

PHYSICAL FUNCTIONING

Allergies:		
Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including inpatient psychiatric, outpatient counseling, substance abuse):		
Dates	Location	Reason
Surgeries:		

CURRENT MEDICATION(S):

Name _____ Date _____

Prescribing Physician	Reason For Medication	Medication Type, Dosage & Frequency	Symptom/ Pain Increased	No Relief	Some Relief	Very Much Relief

Past Medications:

PAIN QUESTIONNAIRE

Pain Management: Are you experiencing pain now? Yes No

If yes, rate the pain on a scale of 1-10 (with 10 being the severest)

Are you receiving care for the pain? Yes No

NUTRITION

Appetite: Good Fair Poor, please explain below

Recently gained/lost significant weight

Special dietary needs

Food allergies

Comments:

SOCIAL

Supportive Social Network? (Rate the network using a scale of 1 Weak to 5 Strong)

Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	

LIVING SITUATION

Name _____ Date _____

<input type="checkbox"/> Housing Adequate	<input type="checkbox"/> Housing Dangerous	<input type="checkbox"/> Ward of State/Tribal Court	<input type="checkbox"/> Dependent on Others
<input type="checkbox"/> Housing Overcrowded	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Homeless	<input type="checkbox"/> At Risk of Homelessness
Additional Information:			

EMPLOYMENT: CURRENTLY EMPLOYED?

<input type="checkbox"/> Yes	Employer:	Employment: Currently Employed?	
<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Supervisor Conflict	<input type="checkbox"/> Co-worker Conflict
<input type="checkbox"/> No	Last Employer:		Reason for Leaving:
<input type="checkbox"/> Never Employed	<input type="checkbox"/> Disabled	<input type="checkbox"/> Student	<input type="checkbox"/> Unstable Work History

FINANCIAL SITUATION

Presence or absence of financial difficulties:			
<input type="checkbox"/> No Current Problems	<input type="checkbox"/> Large Indebtedness	<input type="checkbox"/> Relationship Conflicts Over Finances	
<input type="checkbox"/> Impulsive Spending	<input type="checkbox"/> Poverty or Below	<input type="checkbox"/> Financial Difficulties	
Source of Income (choose all that apply)			
Employed:		Unemployed:	
<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Actively seeking work	<input type="checkbox"/> Public Assistance
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Temporary	<input type="checkbox"/> Not looking for work	
<input type="checkbox"/> Self-Employed			
<input type="checkbox"/> Retirement	<input type="checkbox"/> SSD	<input type="checkbox"/> SSDI	<input type="checkbox"/> SSI
<input type="checkbox"/> Medical Disability via Employer		<input type="checkbox"/> Other:	

MILITARY HISTORY

<input type="checkbox"/> Never enlisted in Armed Forces, OR	Combat:	Type of Discharge:	
<input type="checkbox"/> Branch of Service:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Honorable	<input type="checkbox"/> Medical
		<input type="checkbox"/> Dishonorable	<input type="checkbox"/> Other:

LEGAL STATUS SCREENING

Past or current legal problems (select all that apply)?		
<input type="checkbox"/> None	<input type="checkbox"/> Gangs	<input type="checkbox"/> DUI/DWI
<input type="checkbox"/> Arrests	<input type="checkbox"/> Conviction	<input type="checkbox"/> Detention
<input type="checkbox"/> Jail	<input type="checkbox"/> Probation	<input type="checkbox"/> Other:
If yes to any of the above, please explain:		
Any court-ordered treatment? <input type="checkbox"/> Yes (explain below) <input type="checkbox"/> No		
Ordered by	Offense	Length of Time

SEXUAL ORIENTATION

<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Bisexual
<input type="checkbox"/> Homosexual	<input type="checkbox"/> Transgendered
<input type="checkbox"/> N/A at this time	

EDUCATION

Educational Level (select one):	<input type="checkbox"/> less than 12 years – enter grade completed	<input type="checkbox"/> Some college or tech school
<input type="checkbox"/> High School Grad/GED	<input type="checkbox"/> College Graduate	
If still attending, current School/Grade:		
Vocational School/Skill Area:		
College/Graduate School – Years Completed/Major:		

Functional Assessment

Use or Need assistive or adaptive devices (Select all apply)			
<input type="checkbox"/> None	<input type="checkbox"/> Glasses	<input type="checkbox"/> Walker	<input type="checkbox"/> Braille
<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Cane	<input type="checkbox"/> Crutches	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Translated Written Information	<input type="checkbox"/> Translator for Speaking	<input type="checkbox"/> Other:	
<input type="checkbox"/> History of falls? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:			

LEISURE & RECREATION

Which of the following you enjoy(Select all that apply)	
<input type="checkbox"/> Spend Time with Friends	<input type="checkbox"/> Sports/Exercise
<input type="checkbox"/> Classes	<input type="checkbox"/> Dancing
<input type="checkbox"/> Time with Family	<input type="checkbox"/> Hobbies
<input type="checkbox"/> Work Part-Time	<input type="checkbox"/> Watch Movies/TV
<input type="checkbox"/> Go "Downtown"	<input type="checkbox"/> Stay at Home
<input type="checkbox"/> Listen to Music	<input type="checkbox"/> Spend Time at Clubs/Bars
<input type="checkbox"/> Go to Casinos	<input type="checkbox"/> Other:
What limits leisure/recreational activities?	

PSYCHOLOGICAL

History of Depressed Mood:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of irritability, anger or violence (tantrums, hurts others, cruel to animals, destroys property):		
Sleep Pattern:	Number of hours per day:	Time to onset of sleep?
Ability to Concentrate: <input type="checkbox"/> Normal <input type="checkbox"/> Difficulty concentrating		
Energy Level: <input type="checkbox"/> Low <input type="checkbox"/> Average/Normal <input type="checkbox"/> High		
History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)? Select all that apply		
<input type="checkbox"/> Intrusive memories, thoughts, perceptions	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Avoiding thoughts, feelings, conversations	<input type="checkbox"/> Numbing/detachment	<input type="checkbox"/> Restricted display of emotions
<input type="checkbox"/> Avoiding people, places, activities	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Irritability
<input type="checkbox"/> Hypervigilance	<input type="checkbox"/> Other:	

BEHAVIORAL ASSESSMENT

DOES NOT APPLY

Drug	Age First Used	Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol			
Cannabis			
Cocaine			
Stimulants (crystal, Speed amphetamines)			
Methamphetamine			
Inhalants (Gas, Paint Glue)			
Hallucinogens LSD PCP Mushroom			
Opioids (heroin Steroids cough)			
Sedative/Hypnotics (Valium, Phenobarb)			
Designer Drugs/Other (herbal, Steroids/Cough syrup)			
Tobacco (smoke, chew)			
Caffeine			

Consequences as a Result of Drug/Alcohol Use (select all that apply) **DOES NOT APPLY**

<input type="checkbox"/> Hangovers	<input type="checkbox"/> DTs/Shakes	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Binges
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Increased Tolerance (need more to get high)	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Left School
<input type="checkbox"/> Lost Job	<input type="checkbox"/> DUIs	<input type="checkbox"/> Assaults	<input type="checkbox"/> Arrests
<input type="checkbox"/> Incarcerations	<input type="checkbox"/> Homicide	<input type="checkbox"/> Other:	

Triggers to use (list all that apply):

Has client had any of the following problem gambling behaviors? Select all that apply: **DOES NOT APPLY**

<input type="checkbox"/> Gambled longer than planned	<input type="checkbox"/> Gambled until last dollar was gone
<input type="checkbox"/> Lost sleep thinking of gambling	<input type="checkbox"/> Used income or savings to gamble while letting bills go unpaid
<input type="checkbox"/> Borrowed money to gamble	<input type="checkbox"/> Made repeated, unsuccessful attempts to stop gambling
<input type="checkbox"/> Been remorseful after gambling	<input type="checkbox"/> Broken the law or considered breaking the law to finance gambling
<input type="checkbox"/> Other:	<input type="checkbox"/> Gambled to get money financial obligations

Risk Taking/Impulsive Behavior (current/pass) – Select all that apply: **DOES NOT APPLY**

<input type="checkbox"/> Unprotected Sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Reckless driving
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Drug Dealing	<input type="checkbox"/> Carrying/using weapon
<input type="checkbox"/> Other:		

Risk Taking/Impulsive Behavior (current/pass) – Select all that apply: **DOES NOT APPLY**

Strengths/Resources (Enter Score if present) 1 = Adequate , 2 = Above Average , 3 = Exceptional

Family Support	Social Support System	Relationship Stability
Intellectual/cognitive Skill	Coping skills & Resiliency	Parenting Skills
Socio-Economic Stability	Communication Skills	Insight & sensitivity
Maturity & Judgment	Motivation for Help	Other:

INSURANCE INFORMATION

Your insurance is a method for you to receive reimbursement for fees you have paid for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, not with our office. Any monies received by our office from the insurance company, above and beyond your indebtedness, will be refunded to you when your bill is paid in full or once your copayment is verified from receiving explanation of benefits/payment from your carrier.

Primary Insurance Company				
Subscriber/Policy Holder:		DOB:	Relationship:	
Subscriber/Policy Member Address (if the same please mark same):				
STREET:		CITY:	STATE:	ZIP CODE:
Policy Number:		Group Number:		
Secondary Insurance Company				
Subscriber/Policy Holder:		DOB:	Relationship:	
Subscriber/Policy Member Address (if the same please mark same):				
STREET:		CITY:	STATE:	ZIP CODE:
Policy Number:		Group Number:		

ASSIGNMENT OF BENEFITS:

I authorize release of all information necessary to process my insurance claims pertinent to care in this office. I assign all medical and/or mental health benefits including major medical benefits to which I am entitled to Nueva Vida Behavioral Health Associates, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Your signature is necessary for us to process any insurance claims and to ensure payment for services rendered.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.
I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**

Client Name (Please print):
Client Signature:
Parent/Guardian Signature:
Relationship:
Date:

ACCEPTANCE OF TREATMENT AND RESPONSIBILITY FOR PAYMENT

NVBHA COPY

I, the undersigned, understand and agree to pay Nueva Vida Behavioral Health Associates, Inc. prior to services. I understand I may have co-pay under my current insurance plan, and/or deductible until the deductible is met and my co-pay will drop, and the remaining balance will be billed to my insurance provider, **and that I will be responsible for any balance for services not covered by my insurance plan. Client and Therapist - Please initial the following:**

I understand that I am responsible for a \$55 cancellation fee, for counseling sessions cancelled less than 24 hours in advance or if I fail to show for a scheduled appointment. The cancellation fee/payment will be charged to my credit card on file unless other arrangements have been made. By initialing here and signing the bottom, I authorize Nueva Vida Behavioral Health Assoc. Inc to keep my signature on file and charge my card for the \$55 fee. ___ / ___ (Client/Therapist Initials to acknowledge policies below)

/___ I understand staff may call to remind me of an appointment; however, this is a courtesy reminder. I will call in advance to cancel to the best of my ability.

/___ I understand that due to my insurance policies, missed appointments or late cancelations (less than 24 hours in advance) are not allowed to be billed to the insurance.

/___ I understand NVBHA has several locations and therapists with diverse backgrounds and specializations. In the event I am not satisfied with my clinician and wish to change my therapist, it is MY responsibility to request a change as long as there is not an excessive numbers of No Call No Shows and/or last minute cancellations.

/___ I understand if I cancel late (less than 24 hours in advance) or no-show for a cumulative total of three appointments, the therapist relationship may be terminated.

If therapy relationship is terminated, Nueva Vida has provided three therapy referrals in the client copy.

- United Way Hotline – 210-227-Help
- Community Counseling Service at OLLU – 210-434-1054
- Center for Health Care Services – 210-261-3350

/___ I understand I am responsible for payment of **\$125** prior to completion of any additional paperwork related to disability, FMLA, etc. I understand that initial disability paperwork is completed according to the psychotherapist's clinical discretion at the second or third session.

/___ Non-Emergency/ Emergency/Crisis Calls/Visits phone calls to clinician are **\$25** per 15 minute increments, except when making an appointment. *If your insurance company does not allow for this service, you are responsible for the billed amount.* Court consultation calls to Attorneys, Therapists, or other Parties related, are charged at **\$25** per 15 minutes.

/___ I understand I am responsible for payment in advance to any court appearance(s) and are non-refundable. The fees will be billed in a 3 hour increment at \$150/hr for AM (\$450) and a 4 hour increment \$150/hr for PM (\$625), or for the entire day at \$1350. This includes stand-by time, as well as, if psychotherapist do not get called.

/___ Clients using a credit card, your card will remain on file and will be automatically charged for co-payments, missed/late/canceled appointments, non-Emergency calls, crisis calls, court consultation related calls, etc., as discussed above. If you decline to leave a method of payment on file with the office, all fees are due on or before the next scheduled session. If fees incurred are not paid, treatment will be terminated.

/___ We have a user-friendly feature for collecting co-payments. The **CardPointe** feature allows client to make a co-payment within the Nueva Vida credit card system through a secure link. This link is sent through an email and/or a text. After 60 days of non-payment the account will be sent to collections with IC System.

<https://nuevavidabehav.securepayments.cardpointe.com>

Co-payments not collected, will be followed up every 5 days with an email, text, and/or phone call, sharing the CardPointe link. Any client with three (3) more unpaid copayments cannot be seen until the balance is paid and current.

Agreement

I have read and understand the conditions and policies stated in this document. I have read Nueva Vida Behavioral Health Associates, Inc. Informed Consent to Behavioral Health Services, which provides information on Limits of Confidentiality, Fees and Other Financial Issues, Emergencies and Phone Calls, as well as General Office Policies. I have read and understand the conditions and policies stated in this document. By signing this agreement, I understand I am responsible for fulfilling my therapeutic and financial responsibilities. I agree to let NVBHA work with me or members of my family, including my children, in psychotherapy as is mutually agreed.

I have read and been offered a copy of the Notice of Policies and Practices to Protect the Privacy of Your Health Information, and I agree to the contents therein.

Client Name (Please print):	Client Signature:
Parent/Guardian Signature:	Relationship:

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	
Client Name:	Client DOB:
Card Type: <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> Amex <input type="checkbox"/> Other:	
Cardholder Name (as shown on Card)	
Card Number:	
Expiration Date (mm/yy):	CVV (from back) :
Cardholder Zip Code (from credit card billing address):	
Receipt Email Address:	

I, _____, authorize Nueva Vida Behavioral Health Associates, Inc. to charge my credit card above for agreed below services. I understand that my information will be saved to secure file for future transactions on my account.

Card Holder Signature

Today's Date

Please initial (Client/Therapist)

I authorize Nueva Vida Behavioral Health Associates, Inc. to keep my signature on file to be charged for visits pertaining to my counseling sessions. *(This will be destroyed when counseling relationship is terminated)*

In Office Visits

Telehealth (Phone/Video) *(I understand my card will be charged when the appointment is confirmed whether I speak with staff, left a voice message, emailed and/or texted)*

Non-Emergent/ Emergent/Crisis Calls/Visits phone calls

I authorize Nueva Vida Behavioral Health Associates, Inc. to charge the remaining balance due after my insurance has processed the claim and sent allowable payment. *(This will be destroyed when counseling relationship is terminated and balance on my account is settled/zero)*

I authorize Nueva Vida Behavioral Health Associates, Inc. to keep my signature on file to be charged a **\$55** no-show or late cancellation fee. *(This will be destroyed when counseling relationship is terminated)*

I authorize Nueva Vida Behavioral Health Associates, Inc. to keep my signature on file to be charged **\$125** for Disability paperwork and/or FMLA paperwork. *(This will be destroyed when counseling relationship is terminated)*

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INFORMED CONSENT TO BEHAVIORAL HEALTH SERVICES

Behavioral Health services are based on a relationship between people that works partly because of clearly defined rights and responsibilities held by each person. You have a right to understand the evaluation and treatment procedure being used with you. It is important to be an informed and knowledgeable client and it is always appropriate to ask questions about your psychotherapist, his or her therapeutic approach, and your progress with the evaluation and/or treatment process. You are free to stop behavioral health services at any time.

It is often helpful to have a written copy of office policies that you may refer to at any time. This document contains important information about professional services and business policies. If you have any questions after reading this form, please feel free to discuss them before signing.

Our psychotherapist _____, is a Psychologist / LPC / LPC-Intern / LMFT/ LCSW / LMSW / PMHNP License #: _____
 Supervisor (if required) _____

Approach to Counseling

Nueva Vida Behavioral Health Associates is a trauma informed agency. Trauma Informed Care acknowledges the need to understand a client's life experiences in order to deliver effective care and has the potential to improve client engagement, treatment adherence, better health outcomes as well as client and staff wellness. Operating as a trauma informed agency means making a commitment to following best practices, policies and ensuring a welcome and supportive environment.

Our approach to counseling varies somewhat with the needs of our clients. Primarily, we utilize a cognitive-behavioral approach based on the principles of self-monitoring and social learning. It is also important to appreciate an individual's developmental history, their family of origin, and their current self/other perceptions. Our style is interactive as we view the therapeutic relationship as a partnership between the client and therapist. Responsibility for change resides with the client with our role being that of information provision, insight reflection, and social support. You should note that therapy produces changes and may unleash strong feelings. You need to be aware of the potential strains on yourself and your relationships which may occur during therapy.

Confidentiality

Naturally, we will need to know a great deal about you. Except for the situations described below, you have the right to privacy during the counseling process. Everyone at our office involved in your care is aware of the importance of confidentiality. Nearly all issues discussed in the course of treatment are strictly confidential. We cannot share any information about our work together without your prior written permission, except in the circumstances outlined below. You may direct us to disclose information with whomever you choose, and you can change your mind and revoke that permission at any time.

You may ask anyone you wish to attend a therapy session with you, but let us know in advance so we can decide what information, if any, you want to be kept confidential during that session. If you are participating in couples or family therapy, please be aware that both you and other individuals in therapy with you are considered to be the "client." It is our policy to openly discuss and agree on how information you provide us individually will be managed. In most cases, we believe it is best to avoid secrets among participants.

It is important that you fully understand the limitations of confidentiality in order for you to make an informed decision regarding what you tell us. By law, we are required to disclose confidential information to the appropriate persons and/or agencies if any of the following conditions exist:

- We evaluate you to be a danger to yourself or others.
- You are a minor, elderly, or disabled and we believe you are the victim of abuse or if you divulge information about such abuse.
- You are involved in legal proceedings in which the court subpoenas your mental health records.
- You waive your rights to privilege or give consent to disclosure of information.
- You are being seen through a work injury referral and workers' compensation is getting billed for your sessions.

Minors

If you are under 18 years of age, please be aware that the law may provide parents with the right to examine your behavioral health records. Because psychotherapy requires trust and privacy to work effectively, it will be important for the therapist, parent(s), and minor to agree on how information will be exchanged during the course of treatment. With adolescents, the clinical goal is typically to maximize privacy, with the exception of issues that compromise the physical safety of the minor. Parents/guardians will be provided with general information on how treatment is proceeding. Before giving parents/guardians any information, we will discuss the matter with the minor and will do my best to resolve any objections the minor may have about what we are prepared to discuss.

Record-keeping

According to the Texas Administrative Code Rules of Practice Title 22 Part 30 Chapter 681 Subchapter B Rule §681.53 5 (V). Prior to the commencement of counseling services to a minor client who is named in a custody agreement or court order, a licensee must obtain and review a current copy of the custody agreement or court order, as well as any applicable part of the divorce decree. A licensee must maintain these documents in the client's record and abide by the documents at all times. When federal or state statutes provide an exemption to secure consent of a parent or guardian prior to providing services to a minor, a licensee must follow the protocol set forth in such federal or state statutes.

We normally keep brief records, noting your participation and a brief discussion of what occurred during our session. You have a right to review your mental health record and to correct any errors in your file. You can request in writing that we send information to any other health care provider. Legally, raw testing data can only be sent to a licensed psychologist. We maintain your records in a secure location to protect your privacy.

Diagnosis

If a third party (i.e., insurance company) is paying for part of your bill, they may require a formal diagnosis as a condition of payment. Diagnoses are technical terms to describe the nature and severity of your problems. If we use a diagnosis, we will discuss this with you.

Insurance

Many insurance plans cover behavioral health services. In order to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. Generally, it is your responsibility to understand your insurance benefits and to file necessary paperwork for reimbursement. You, not your insurance company, are responsible for full payment of the fee to which we have agreed. Payment is due before or at the end of the session unless other arrangements have been made in advance. If this policy causes you undue hardship, please talk with me about other options. Please be sure to fill out insurance/insured information accurately on the office intake form. We will not be responsible for erroneous claims due to incomplete insurance information.

The escalation of health care costs has resulted in an increasing level of complexity about insurance benefits that sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. Such plans are often oriented toward short-term treatment approaches that are designed to resolve specific problems interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In my experience, while quite a great deal can be accomplished in short-term therapy, many clients feel that more services are necessary after insurance benefits expire. Some managed care plans will not allow us to provide services to you once your benefits are no longer available. If this is the case, we can discuss alternate ways of receiving services, including finding another provider who will help you continue your care or paying for services privately.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions.

It is important to remember that you always have the right to pay for our services yourself and avoid the complexities that are described above.

Tele-mental health Services

For those clients who are being treated by telemental health: You hereby consent to engaging in distance counseling as part of your psychotherapy. You understand distance counseling includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video and data communications. You understand that tele-mental health services also involves the communication of medical/mental information both orally and visually. You understand that you have the following rights with respect to distance counseling:

- There are risks and consequences from distance counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of your psychotherapist, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons and/or the electronic storage of your medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of HIPPA-compliant service which is encrypted for video telemental health communications. Further, the contents of my therapist's computer are encrypted.
- If your psychotherapist believes you would be better served by another form of psychotherapeutic services (e.g. face-to-face services, group therapy), you may be could be referred to another psychotherapist who can provide such services.
- There is a risk that services could be disrupted or distorted by unforeseen technical problems
- There is a risk of being overheard by anyone near you if you are not in a private room alone.
- Due to the nature of the interaction, there may be quality differences that are experienced that would not occur in face-to-face interactions. Please let the staff of Nueva Vida or your treating clinician know if you find the quality of audio/visual interactions insufficient for your needs.
- The clinician may be located in Texas or out-of-state which will not allow for him/her to be physically present should an emergency arise; however, the clinician works closely with the staff and clinicians at Nueva Vida to provide emergency psychological evaluation and care if needed on-site.

Client's Rights:

1. You have the right to request face-to-face psychological services instead of Tele-mental health services at any point in the treatment. This will not affect your right to further treatment.
2. You have the right to withdraw your consent to the use of Tele-mental health services at any time during the course of your care. This will not affect your right to further treatment.
3. You have the right to inquire about the security and confidentiality of the audio/visual interactions at any time during your treatment.

Technology

It is the utmost importance to us that we maintain confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we have developed the following policies: (If this is a problem, please feel free to discuss this with your therapist.)

- Cell Phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your counselor may also use a cell phone to contact you.
- Text Messaging and Email: Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information.
- We are required to keep a copy of all emails and texts as part of your clinical record. If you find the need to communicate frequently with your counselor between sessions, it may be that you need to schedule more frequent visits.

Surveillance

NVBHA uses surveillance video cameras in its common areas. Cameras are located outside the building surveillance both entrances, parking lot and playground. One camera is located in the waiting room. One camera are in the reception area. Camera are in the hallways and offices. Surveillance equipment will never be used in private spaces, such as bathrooms or counseling offices.

Worker's Compensation

For those clients who are being treated under Worker's Compensation benefits, we will bill the Insurance carrier for services. Please also be aware that your mental health records will be forwarded to the insurance company as documentation of the services provided before we can be reimbursed. Your records may also be forwarded to your primary physician. Any other requests for your records must be accompanied by a properly executed Release of Information, which is available in this office.

Emergencies and Phone Calls

NVBHA can be reached by phone (210-616-0828) from 8:00 A.M. to 6:00 P.M., Monday through Friday and 8:00 A.M. to 5:00 P.M. We ask that you seek help immediately from your physician or a hospital emergency room if you have an emergency. IF YOU ARE UNABLE TO MAKE IT TO THE HOSPITAL, CALL 911. University Hospital (210-358-2524), 4502 Medical Drive in San Antonio, has psychiatric care available in the emergency room at all times, as do most other community hospitals.

Ethics and Professional Standards

As licensed professional counselors, licensed marriage family therapists, psychologists, and psychiatric nurse practitioners are regulated by the Texas State Board of Executive Counsel. The number for the Texas State Board of Executive Counsel is 800-252-8154. If you have any concerns about the course of evaluation or treatment, please discuss them with me. We look forward to working with you.

CLIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

For the purposes of this Consent Form, "Office" shall refer to: **Nueva Vida Behavioral Health Associates**.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Signed by: _____ / _____
Signature of Client or Legal Guardian Print Name of Client or Legal Guardian, if applicable/Relationship to Client

Date: _____



Nueva Vida Behavioral Health Associates, Inc.

E-Fax: (855) 616-0829

MEDICAL CENTER
9500 Tioga Drive
San Antonio, Texas 78230
210-616-0828

DOWNTOWN/WESTSIDE
700 S. Zarzamora
San Antonio, Texas 78207
210-375-4593

SOUTHSIDE
102 Palo Alto Rd., Suite 300
San Antonio, Texas 78211
210-922-0828

Date Request:
Phone:
Fax:

Consent to Obtain Information

I hereby authorize and request _____ to disclose my records which were obtained during the course of my treatment.

Client: _____ Date of Birth: ____ / ____ / ____

Release of Information To: **Nueva Vida Behavioral Health Associates, Inc.**
Name of person or agency

9500 Tioga Drive, Ste A **San Antonio** **Texas** **78229**
Street City State Zip

Phone Number: **(210) 616-0828** Fax Number: **(855) 616-0829**

Information Requested:

- All Medical Records
- Neurological Evaluation
- Psychiatric Evaluation
- Psychological/Neuropsychological Evaluation
- Legal Records
- Other: _____

Consent to Release Information

I hereby authorize Nueva Vida Behavioral Health Associates, Inc. to disclose my records to _____ which were obtained during the course of my treatment.

Client: _____ Date of Birth: ____ / ____ / ____

Consent to Decline Release Information

This Consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance heron, and if not earlier revoked

Decline to allow authorization of communication

Client Signature (if over 18)

_____-_____-_____
Date

Parent, guardian or authorized Representative of the client

_____-_____-_____
Date



Nueva Vida Behavioral Health Associates, Inc.

E-Fax: (855) 616-0829

MEDICAL CENTER
9500 Tioga Drive
San Antonio, Texas 78230
210-616-0828

DOWNTOWN/WESTSIDE
700 S. Zarzamora
San Antonio, Texas 78207
210-375-4593

SOUTHSIDE
102 Palo Alto Rd., Suite 300
San Antonio, Texas 78211
210-922-0828

Authorization for Use or Disclosure of Protected Medical Information

Date Requested: ____/____/____

Client Information

Name: _____ DOB: ____/____/____

Recipient Information

I, _____, (relationship to client) _____

do hereby authorize Nueva Vida Behavioral Health Associates, Inc. to **release and disclose any and all medical information** during the course of treatment to the following individuals:

1. Name: _____ Relationship to Client: _____

2. Name: _____ Relationship to Client: _____

3. Name: _____ Relationship to Client: _____

4. Name: _____ Relationship to Client: _____

5. Name: _____ Relationship to Client: _____

All listed individuals providing transportation must show valid identification at time of appointment in order for services to be rendered.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance heron, and if not earlier revoked, it shall terminate **one (1) year** without express revocation.

Client Signature (if over 18 years old)

____/____/____
Date

Parent, Legal Guardian, or Authorized Representative of the Client

____/____/____
Date

BAI INVENTORY

Name: _____

Today's Date: ____-____-____

**15 Yrs & Older
Complete**

Below is a list of common symptoms of anxiety. Please carefully read each item. Indicate how much you have been bothered by each symptom during the **past week, including today**, by checking off the corresponding box in the column next to each symptom.

	Not At All (0)	Mildly (1)	Moderately (2)	Severely (3)
SUBJECTIVE				
Unable to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of the worst happening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Terrified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PANIC				
Heart pounding or racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of choking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROPHYSIOLOGICAL				
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wobbliness in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy or lightheaded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unsteady	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shaky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Faint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AUTONOMIC				
Feeling hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion or discomfort in abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face flushed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (not due to heat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10 – 18, Mild
19 – 29, Moderate
30 – 63, Severe _____, _____

BDI INVENTORY

Name: _____

Today's Date: ____-____-____ **15 Yrs & Older
Complete**

INSTRUCTIONS: This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, check off the box next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today**. If several statements within a group seem to apply equally check off each one. **Be sure to read all the statements in each group before making your choice.**

<p>SADNESS</p> <p><input type="checkbox"/> - I do not feel sad.</p> <p><input type="checkbox"/> - I feel sad.</p> <p><input type="checkbox"/> - I am sad all the time and I can't snap out of it.</p> <p><input type="checkbox"/> - I am so sad or unhappy that I can't stand it.</p> <p>PESSIMISM</p> <p><input type="checkbox"/> - I am not particularly discouraged about the future.</p> <p><input type="checkbox"/> - I feel discouraged about the future.</p> <p><input type="checkbox"/> - I feel I have nothing to look forward to.</p> <p><input type="checkbox"/> - I feel that the future is hopeless and that things cannot improve.</p> <p>DISSATISFACTION</p> <p><input type="checkbox"/> - I get as much satisfaction out of things as I used to.</p> <p><input type="checkbox"/> - I don't enjoy things the way I used to.</p> <p><input type="checkbox"/> - I don't get real satisfaction out of anything anymore.</p> <p><input type="checkbox"/> - I am dissatisfied or bored with everything.</p> <p>CRYING</p> <p><input type="checkbox"/> - I don't cry any more than usual.</p> <p><input type="checkbox"/> - I cry more now than I used to.</p> <p><input type="checkbox"/> - I cry all the time now.</p> <p><input type="checkbox"/> - I used to be able to cry, but now I can't cry even though I want to.</p> <p>IRRITABILITY</p> <p><input type="checkbox"/> - I am no more irritated now than I ever am.</p> <p><input type="checkbox"/> - I get annoyed or irritated more easily than I used to.</p> <p><input type="checkbox"/> - I feel irritated all the time now.</p> <p><input type="checkbox"/> - I don't get irritated at all by the things that used to irritate me.</p> <p>SUICIDAL IDEAS</p> <p><input type="checkbox"/> - I don't have any thoughts of killing myself.</p> <p><input type="checkbox"/> - I have thoughts of killing myself, but I would not carry them out.</p> <p><input type="checkbox"/> - I would like to kill myself.</p> <p><input type="checkbox"/> - I would kill myself if I had the chance.</p> <p>INDECISIVENESS</p> <p><input type="checkbox"/> - I make decisions about as well as I ever could.</p> <p><input type="checkbox"/> - I put off making decisions more than I used to.</p> <p><input type="checkbox"/> - I have greater difficulty in making decisions than before.</p> <p><input type="checkbox"/> - I can't make decisions at all anymore.</p> <p>PUNISHMENT</p> <p><input type="checkbox"/> - I don't feel I am being punished.</p> <p><input type="checkbox"/> - I feel I may be punished.</p> <p><input type="checkbox"/> - I expect to be punished.</p> <p><input type="checkbox"/> - I feel I am being punished</p> <p>SELF-ACCUSATIONS</p> <p><input type="checkbox"/> - I don't feel I am any worse than anybody else.</p> <p><input type="checkbox"/> - I am most critical of myself for my weaknesses or mistakes.</p> <p><input type="checkbox"/> - I blame myself all the time for my faults.</p> <p><input type="checkbox"/> - I blame myself for everything bad that happens.</p> <p>SELF-DISLIKE</p> <p><input type="checkbox"/> - I don't feel disappointed in myself.</p> <p><input type="checkbox"/> - I am disappointed in myself.</p> <p><input type="checkbox"/> - I am disgusted with myself.</p> <p><input type="checkbox"/> - I hate myself.</p> <p>GUILT</p> <p><input type="checkbox"/> - I don't feel particularly guilty.</p> <p><input type="checkbox"/> - I feel guilty a good part of the time.</p> <p><input type="checkbox"/> - I feel quite guilty most of the time.</p> <p><input type="checkbox"/> - I feel guilty all of the time.</p>	<p>SENSE OF FAILURE</p> <p><input type="checkbox"/> - I do not feel like a failure.</p> <p><input type="checkbox"/> - I feel I have failed more than the average person.</p> <p><input type="checkbox"/> - As I look back on my life, all I can see is a lot of failures.</p> <p><input type="checkbox"/> - I feel I am a complete failure as a person.</p> <p>BODY IMAGE CHANGE</p> <p><input type="checkbox"/> - I don't feel I look any worse than I used to.</p> <p><input type="checkbox"/> - I am worried that I am looking old or Unattractive.</p> <p><input type="checkbox"/> - I feel that there are permanent changes in my appearance that make me look unattractive.</p> <p><input type="checkbox"/> - I believe that I look ugly.</p> <p>SOMATIC PREOCCUPATION</p> <p><input type="checkbox"/> - I am no more worried about my health than usual.</p> <p><input type="checkbox"/> - I am worried about physical problems such as aches and pains; or upset stomach, or constipation.</p> <p><input type="checkbox"/> - I am very worried about physical problems and it's hard to think of much else.</p> <p><input type="checkbox"/> - I am so worried about my physical problems that I cannot think about anything else</p> <p>FATIGABILITY</p> <p><input type="checkbox"/> - I don't get more tired than usual.</p> <p><input type="checkbox"/> - I get tired more easily than I used to.</p> <p><input type="checkbox"/> - I get tired from doing almost anything.</p> <p><input type="checkbox"/> - I am too tired to do anything.</p> <p>INSOMNIA</p> <p><input type="checkbox"/> - I can sleep as well as usual.</p> <p><input type="checkbox"/> - I don't sleep as well as I used to.</p> <p><input type="checkbox"/> - I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.</p> <p><input type="checkbox"/> - I wake up several hours earlier than I used to and cannot get back to sleep.</p> <p>LOSS OF APPETITE</p> <p><input type="checkbox"/> - My appetite is no worse than usual.</p> <p><input type="checkbox"/> - My appetite is not as good as it used to be.</p> <p><input type="checkbox"/> - My appetite is much worse now.</p> <p><input type="checkbox"/> - I have no appetite at all anymore.</p> <p>WEIGHT LOSS</p> <p><input type="checkbox"/> - I haven't lost much weight, if any lately.</p> <p><input type="checkbox"/> - I have lost more than 5 pounds.</p> <p><input type="checkbox"/> - I have lost more than 10 pounds.</p> <p><input type="checkbox"/> - I have lost more than 15 pounds.</p> <p>I am purposely trying to lose weight by eating less. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>LOSS OF LIBIDO</p> <p><input type="checkbox"/> - I have not noticed any recent change in my interest in sex.</p> <p><input type="checkbox"/> - I am less interested in sex than I used to be.</p> <p><input type="checkbox"/> - I am much less interested in sex now.</p> <p><input type="checkbox"/> - I have lost interest in sex completely.</p> <p>WORK DIFFICULTY</p> <p><input type="checkbox"/> - I can work about as well as before.</p> <p><input type="checkbox"/> - It takes an extra effort to get started at doing something.</p> <p><input type="checkbox"/> - I have to push myself very hard to do anything.</p> <p><input type="checkbox"/> - I can't do any work at all.</p> <p>_____, _____</p> <p>10 - 18, Mild-Moderate 19 - 29, Moderate-Severe 30 - 63, Severe-Extreme</p>
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Sleep Questionnaire

Name: _____

Today's Date: ____-____-____

**15 Yrs & Older
Complete**

"Check" how often each of the following sleep symptoms have been a problem during this **past week**.

Symptoms	Never a Problem 1	Seldom a Problem 2	Sometimes a Problem 3	Often a Problem 4	Almost Always a Problem 5
Trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waking up during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waking up too early in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot stop thinking while trying to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dread going to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping during day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gasping for air during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs jerk during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps, pain, or crawling sensation in legs while lying in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involuntarily falling asleep during day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscles become paralyzed briefly during day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strange feeling at beginning of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep does not seem refreshing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP Problem Cause(s)

"X"	Sleep Problem Caused and/or Made Worse by:
<input type="checkbox"/>	Physical pain
<input type="checkbox"/>	Too restless/tense or tired
<input type="checkbox"/>	Personal stress
<input type="checkbox"/>	Frustration and anger
<input type="checkbox"/>	Worries or fears about current injury, re-injury, stressful problems
<input type="checkbox"/>	Wrong or side effects from medication
<input type="checkbox"/>	Environment: Noisy, poor mattress, etc.
<input type="checkbox"/>	Afraid to go to sleep
<input type="checkbox"/>	Cannot stop thinking
<input type="checkbox"/>	Sleep disturbance is a viscous pattern or habit now.

Sleep Problem Severity Scale

0 – 15, None
 16 – 30, Mild
 31 – 45, Moderate to Serious
 46 – 60, Severe
 61 – 75, Extreme

Current Score/Rating: _____

SLEEP Problem Onset: How long have you had your sleep problem(s): _____

SLEEP Problem Frequency: During the past week, how many nights did you have trouble sleeping? ____ out of 7 days.

SLEEP Length/Duration: Within a 24-hour period, how many hours of sleep did you get on average this past week? ____ hours.

SLEEP Onset/Latency: This past week on average, how long did it take you to fall asleep? _____

SLEEP Awakenings: This past week on average, how many times did you wake up during the night? _____

After awakening how long did it take you to fall back to sleep? _____

SLEEP Efficiency: In general, how refreshing or energizing was your sleep this past week? _____

SLEEP Problem Treatment

Medication Management: Have you used any medications to help you sleep? _____

If you have, what medications have you used? _____

Did you use any sleep medications? ____ If so, what did you use, and how often did you use them? _____

Self-Medication: Did you use alcohol, nonprescription, or other substances to help you sleep? _____

If so, how often and what do you use? _____

Other Treatment(s): Describe other treatments or strategies you used to help you sleep _____

How well did the treatment(s) or strategies work? _____

What has helped you sleep most during this past week? _____

Nueva Vida Behavioral Health Associates Behavioral Rating Scale - (Page 1 of 2)

Client Name: _____

Age: _____

Medicaid #/Member ID#: _____

Today's Date: _____

Person Completing form: _____

All Ages Complete

Please check off the box that best describes the frequency/severity of the problem in the person you are describing:

1=Not at All 2 = A Little 3= Moderately or Somewhat 4=Quite a bit 5=Extremely

Depression/Anxiety					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem; shyness or problems making friends; sensitivity to criticism or rejection; feeling or inadequacy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling down or blue, irritable, crying easily; feeling easily hurt; quick mood changes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling hopeless about the future, thoughts of hurting self, thoughts about death or dying
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separation anxiety; clinging to and/or sleeping with parents; fearful of being away from parents; difficulty going to school
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worrying about things too much; feeling tense, anxious, nervous, or shaking; phobias
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares; easily startled; avoidance; flashbacks related to past abuse or other traumas

Anger/Irritability/Behavioral Problems					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger control problems; thoughts about hurting others; violence; fighting, temper tantrums; cruelty to animals; stealing; fire setting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stubborn; defiant, trouble with authority; gang involvement, cult involvement

Relationships					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with parenting, disciplining, and/or communicating with your child
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital problems; family conflict; sibling fighting; conflicts with co-workers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship problems, distrust, interpersonal isolation, frequent arguments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abusive relationships; victim of abuse; perpetrator of abuse

Addictions/Compulsions					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive-compulsive behaviors (ie., cleaning, cooking, exercise, rituals, gambling counting); odd thoughts that you can't get out of your head, perfectionism; excessive need for control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug abuse; describe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue; low energy; problems concentrating

Sleep/Eating/Developmental/Physical					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with eating/appetite (changing in appetite/weight, bingeing/purging)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aches and pains; lots of physical symptoms (without a known physical cause)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbance (trouble falling asleep, restless sleep, waking to early and being unable to fall back asleep, sleeping too much)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Developmental delays in speech/language, toilet training, motor skills, social/emotional functioning; cognitive/academic skills

Nueva Vida Behavioral Health Associates
Behavioral Rating Scale – (Page 2 of 2)

Client Name: _____

Date: _____

Medicaid #/Member ID#: _____

All Ages Complete

1=Not at All 2 = A Little 3= Moderately or Somewhat 4=Quite a bit 5=Extremely

Academic/Learning/Vocational					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing grades in school; declining work performance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning problems; problems with memory; slowed thinking

Thought Process					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices or seeing visions; mental confusion; odd beliefs; paranoia

Stress					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Financial problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal problems; pending court case or lawsuit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress Management problems; difficulties coping and/or relaxing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work related stress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family problems (check those that apply)
					<input type="checkbox"/> Children difficult to manage
					<input type="checkbox"/> Marital stress
					<input type="checkbox"/> Spouse abuse
					<input type="checkbox"/> Child abuse

Inattention/Hyperactivity					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactive; impulsive; restless
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattentive, disorganization, forgetful, easily distress

Other problems not listed previously:

Child/Adolescent Strengths
<input type="checkbox"/> creative <input type="checkbox"/> curious <input type="checkbox"/> open-minded <input type="checkbox"/> loves to learn <input type="checkbox"/> has a sense of perspective that he/she offer to others <input type="checkbox"/> authentic <input type="checkbox"/> brave <input type="checkbox"/> can be persistent when she/she wants something <input type="checkbox"/> approach life with excitement and energy kind <input type="checkbox"/> value love and relationships with others <input type="checkbox"/> aware of how others are feeling <input type="checkbox"/> fair <input type="checkbox"/> has good leadership skills <input type="checkbox"/> works well with others <input type="checkbox"/> can forgive others <input type="checkbox"/> modest <input type="checkbox"/> makes choices carefully and thoughtfully <input type="checkbox"/> regulates his/her own feelings <input type="checkbox"/> appreciates beautiful things <input type="checkbox"/> thankful and grateful <input type="checkbox"/> has hope <input type="checkbox"/> has a good sense of humor

Nueva Vida Behavioral Health Associates
SYMPTOMS DISTRESS CHECKLIST
(Adapted from SCL-90 and BST)

Client Name: _____
 Medicaid #/Member ID#: _____
 Person Completing form: _____

Age: _____
 Today's Date: _____
All Ages Complete

These statements are about how much you have been distressed or bothered by something during the last seven (7) days. Please check off the box that best describes how you felt for each of the statements below:

1=Not at All 2 = A Little 3= Moderately or Somewhat 4=Quite a bit 5=Extremely

During the past 7 days about how much were you distressed or bothers by:					
1	2	3	4	5	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling so restless you couldn't sit still
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Being suddenly scared for no reason
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of worthlessness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling blue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spells of terror or panic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy feeling in arms or legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling lonely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling tense or keyed up
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling lonely even when you are with people
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling afraid to go out of your home alone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling no interest in things
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling fearful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling weak in parts of your body
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness or shakiness inside
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling afraid in open spaces or on the streets

 Clinician Signature

 Date

 Adult Client or Guardian Signature

 Date

Nueva Vida Behavioral Health Associates, Inc./Casa De Familia LLC

LIABILITY WAIVER AND HOLD HARMLESS AGREEMENT

As parent or legal guardian of the child whose name is set forth below (who is referred to herein as the "Participant") and in consideration of the Participant being permitted to participate in the Activities (as defined below) conducted by Nueva Vida Behavioral Health Associates, Inc / Casa De Familia LLC (NVBHA/CDF), the Participant and I agree as follows:

1. Activities - The Participant will participate in various activities offered by NVBHA/CDF (the "Activities"), including but not limited to, the following:

2. Assumption Of Risk - I understand that the Activities entail the risk of severe bodily injury to the Participant. Injuries that could result will vary, but may include (a) minor injuries such as scratches, bruises and sprains; (b) major injuries such as eye injury or loss of sight, joint or back injuries and concussions; and (c) catastrophic injuries, including paralysis and even death. Notwithstanding these risks and other hazards that may be foreseeable but not specifically identified herein, I, for myself and the Participant and our respective heirs, personal representatives and assigns, understand, acknowledge, and expressly and voluntarily assume all risks and full responsibility for any injury arising out of or related to the Activities.

3. Release, Discharge and Agreement Not To Sue - I, for myself and the Participant and our respective heirs, personal representatives and assigns, do hereby release, discharge and agree not to sue NVBHA/CDF and its managers, members, employees and/or other agents, for any injury to or death of the Participant arising, directly or indirectly, from participation in the Activities. This release, discharge and covenant not to sue shall relate to any and all claims or legal rights now existing or arising in the future, including claims and legal rights arising out of any negligence of NVBHA/CDF and/or its managers, members, employees and/or other agents and any other breach of a legal duty arising out of common law, statute, contract or otherwise.

4. Indemnification And Hold Harmless – I agree to indemnify NVBHA/CDF and hold NVBHA/CDF harmless from, without limitation, any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees and costs, incurred due to claims brought by any third party as a result of or arising out of the Participant's involvement in the Activities and to reimburse NVBHA/CDF for any such costs, expenses and fees as they are incurred.

5. Parent Or Legal Guardian Certification And Consent -I hereby certify that I am the parent or legal guardian of the Participant whose name appears below, and I have authority to waive rights on behalf of the minor Participant. I have read and I understand all of the provisions of this document and the risks of the Activities. I understand that the Activities could cause injury and even death. I acknowledge that I have read and understand the terms of this document and I am freely and voluntarily signing this document.

6. Severability - This document is intended to be as broad and inclusive as is permitted by the laws of the State of Texas and if any provision (or a part of any provision) contained herein is deemed to be invalid, the balance of the provisions shall continue in full legal force and effect, notwithstanding such invalidity.

Parent or Legal Guardian's Signature: _____ Printed Name: _____

Participant's Name: _____ Date of Birth ____/____/____

Participant's Name: _____ Date of Birth ____/____/____

Home Address: _____ Zip Code: _____

Parent/Guardian E-mail address: _____ Primary Phone: _____

Today's Date: ____/____/____

