Nueva Vida Behavioral Health Associates, Inc.

E-Fax: (855) 616-0829

MEDICAL CENTER	DOWNTOWN/WESTSIDE	SOUTHSIDE
9500 Tioga Drive	700 S. Zarzamora	102 Palo Alto Rd., Suite 300
San Antonio, Texas 78230	San Antonio, Texas 78207	San Antonio, Texas 78211
210-616-0828	210-375-4593	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: **Street:** **City/State:** **Zip Code:**	**Sex at Birth:** Boy ☐ Girl ☐ **Phone #:** **Email:** **Social security # :**
Marital/Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ 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:

Name_____ Date_____

FAMILY HISTORY

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

(CHOOSE ALL THAT APPLY) ☐ NONE APPLY

☐ Food Stamp Recipient	☐ Protective Services (APS/CPS)
☐ ANF Recipient	☐ Court Ordered Services
☐ SSI Recipient	☐ On Probation
☐ SDI Recipient	☐ On Parole
☐ SSA (retirement) Recipient	☐ Currently pregnant
☐ Retirement Income	☐ Woman w/dependents
☐ Medicare Recipient	☐ Physical Disability
☐ Medicaid Recipient	☐ Severely Mentally Ill
☐ Homeless	☐ Developmentally Disabled
☐ 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:

Name_____ Date_____

CURRENT MEDICATION(S):

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

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	

Name_____ Date_____

LIVING SITUATION

☐ Housing Adequate	☐ Housing Dangerous	☐ Ward of State/Tribal Court	☐ Dependent on Others
☐ Housing Overcrowded	☐ Incarcerated	☐ Homeless	☐ At Risk of Homelessness
Additional Information:			

EMPLOYMENT: CURRENTLY EMPLOYED?

☐ Yes	Employer:	Employment: Currently Employed?	
☐ Satisfied	☐ Dissatisfied	☐ Supervisor Conflict	☐ Co-worker Conflict
☐ No	Last Employer:	Reason for Leaving:	
☐ Never Employed	☐ Disabled	☐ Student	☐ Unstable Work History

FINANCIAL SITUATION

Presence or absence of financial difficulties:

☐ No Current Problems ☐ Large Indebtedness ☐ Relationship Conflicts Over Finances

☐ Impulsive Spending ☐ Poverty or Below ☐ Financial Difficulties

Source of Income (choose all that apply)

Employed:	**Unemployed:**	
☐ Full-time ☐ Part-time	☐ Actively seeking work	
☐ Seasonal ☐ Temporary	☐ Not looking for work	☐ Public Assistance
☐ Self-Employed		
☐ Retirement ☐ SSD	☐ SSDI	☐ SSI
☐ Medical Disability via Employer	☐ Other:	

MILITARY HISTORY

☐ Never enlisted in Armed Forces, OR	Combat:	Type of Discharge:
☐ Branch of Service:	☐ Yes ☐ No	☐ Honorable ☐ Medical
		☐ Dishonorable ☐ Other:

LEGAL STATUS SCREENING

Past or current legal problems (select all that apply)?

☐ None	☐ Gangs	☐ DUI/DWI
☐ Arrests	☐ Conviction	☐ Detention
☐ Jail	☐ Probation	☐ Other:

If yes to any of the above, please explain:

Any court-ordered treatment? ☐ Yes (explain below) ☐ No

Ordered by	Offense	Length of Time

Name_____ Date_____

SEXUAL ORIENTATION

☐ Heterosexual	☐ Bisexual
☐ Homosexual	☐ Transgendered
☐ Not listed (please specify):_____	

EDUCATION

Educational Level (select one): ☐ less than 12 years – enter grade completed ☐ Some college or tech school
☐ High School Grad/GED ☐ 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)			
☐ None	☐ Glasses	☐ Walker	☐ Braille
☐ Hearing Aids	☐ Cane	☐ Crutches	☐ Wheelchair
☐ Translated Written Information	☐ Translator for Speaking	☐ Other:	
☐ History of falls? ☐ Yes ☐ No Explain:			

LEISURE & RECREATION

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

PSYCHOLOGICAL

History of Depressed Mood: ☐ Yes ☐ 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: ☐ Normal ☐ Difficulty concentrating
Energy Level: ☐ Low ☐ Average/Normal ☐ High
History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)? Select all that apply

☐ Intrusive memories, thoughts, perceptions	☐ Nightmares	☐ Flashbacks
☐ Avoiding thoughts, feelings, conversations	☐ Numbing/detachment	☐ Restricted display of emotions
☐ Avoiding people, places, activities	☐ Poor sleep	☐ Irritability
☐ Hypervigilance	☐ Other:	

Name_____ Date_____

BEHAVIORAL ASSESSMENT ☐ DOES NOT APPLY

Drug	Age First Used	Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol			
Cannabis/CBD			
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**

☐ Hangovers	☐ DTs/Shakes	☐ Blackouts	☐ Binges
☐ Overdoses	☐ Increased Tolerance (need more to get high)	☐ GI Bleeding	☐ Liver Disease
☐ Sleep Problems	☐ Seizures	☐ Relationship Problems	☐ Left School
☐ Lost Job	☐ DUIs	☐ Assaults	☐ Arrests
☐ Incarcerations	☐ Homicide	☐ 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**

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

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

☐ Unprotected Sex	☐ Shoplifting	☐ Reckless driving
☐ Gang Involvement	☐ Drug Dealing	☐ Carrying/using weapon
☐ 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		Copping 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 deposition preparation, deposition appearance, court appearance(s) and this is 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:

MEDICAID CLIENTS DISREGARD THIS PAGE ***(unless CHIP plan)***

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: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex ☐ 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)*

Nueva Vida Behavioral Health Associates, Inc.
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Name_____ Date_____

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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-Associate / LMFT/ LCSW / LMSW / PMHNP / LCDC/ Graduate Student Intern 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.

Name_____ Date_____

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.

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.

Safety Monitoring

NVBHA at the Tioga location uses security video cameras in its common areas. Cameras are located outside the building, monitoring both entrances, the parking lot, and the playground. One camera is located in the waiting room, and another is in the reception area.

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 Behavioral Health Executive Council. The number for the Texas Behavioral Health Executive Council is 512-305-7700. 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

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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

Name: _____

Date: _____

Last 4 SSN: _____

13 years old and up complete.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1 Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name: _____

Date: _____

Last 4 SSN: _____

13 years old and up complete.

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Column totals _____ + _____ + _____ + _____

= Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult ...** ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety Score

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

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	☐	☐	☐	☐	☐
Waking up during sleep	☐	☐	☐	☐	☐
Waking up too early in the morning	☐	☐	☐	☐	☐
Cannot stop thinking while trying to fall asleep	☐	☐	☐	☐	☐
Dread going to bed	☐	☐	☐	☐	☐
Sleeping during day	☐	☐	☐	☐	☐
Gasping for air during sleep	☐	☐	☐	☐	☐
Morning fatigue	☐	☐	☐	☐	☐
Legs jerk during sleep	☐	☐	☐	☐	☐
Cramps, pain, or crawling sensation in legs while lying in bed	☐	☐	☐	☐	☐
Involuntarily falling asleep during day	☐	☐	☐	☐	☐
Muscles become paralyzed briefly during day	☐	☐	☐	☐	☐
Strange feeling at beginning of sleep	☐	☐	☐	☐	☐
Sleep does not seem refreshing	☐	☐	☐	☐	☐
Bad dreams	☐	☐	☐	☐	☐

SLEEP Problem Cause(s)

"X"	Sleep Problem Caused and/or Made Worse by:
☐	Physical pain
☐	Too restless/tense or tired
☐	Personal stress
☐	Frustration and anger
☐	Worries or fears about current injury, re-injury, stressful problems
☐	Wrong or side effects from medication
☐	Environment: Noisy, poor mattress, etc.
☐	Afraid to go to sleep
☐	Cannot stop thinking
☐	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	
☐	☐	☐	☐	☐	Low self-esteem; shyness or problems making friends; sensitivity to criticism or rejection; feeling or inadequacy
☐	☐	☐	☐	☐	Feeling down or blue, irritable, crying easily; feeling easily hurt; quick mood changes
☐	☐	☐	☐	☐	Feeling hopeless about the future, thoughts of hurting self, thoughts about death or dying
☐	☐	☐	☐	☐	Separation anxiety; clinging to and/or sleeping with parents; fearful of being away from parents; difficulty going to school
☐	☐	☐	☐	☐	Worrying about things too much; feeling tense, anxious, nervous, or shaking; phobias
☐	☐	☐	☐	☐	Nightmares; easily startled; avoidance; flashbacks related to past abuse or other traumas

Anger/Irritability/Behavioral Problems					
☐	☐	☐	☐	☐	Anger control problems; thoughts about hurting others; violence; fighting, temper tantrums; cruelty to animals; stealing; fire setting
☐	☐	☐	☐	☐	Stubborn; defiant, trouble with authority; gang involvement, cult involvement

Relationships					
☐	☐	☐	☐	☐	Problems with parenting, disciplining, and/or communicating with your child
☐	☐	☐	☐	☐	Marital problems; family conflict; sibling fighting; conflicts with co-workers
☐	☐	☐	☐	☐	Relationship problems, distrust, interpersonal isolation, frequent arguments
☐	☐	☐	☐	☐	Abusive relationships; victim of abuse; perpetrator of abuse

Addictions/Compulsions					
☐	☐	☐	☐	☐	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
☐	☐	☐	☐	☐	Alcohol or drug abuse; describe
☐	☐	☐	☐	☐	Fatigue; low energy; problems concentrating

Sleep/Eating/Developmental/Physical					
☐	☐	☐	☐	☐	Problems with eating/appetite (changing in appetite/weight, bingeing/purging)
☐	☐	☐	☐	☐	Aches and pains; lots of physical symptoms (without a known physical cause)
☐	☐	☐	☐	☐	Sleep disturbance (trouble falling asleep, restless sleep, waking to early and being unable to fall back asleep, sleeping too much)
☐	☐	☐	☐	☐	Sexual problems
☐	☐	☐	☐	☐	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	Failing grades in school; declining work performance
☐	☐	☐	☐	☐	Learning problems; problems with memory; slowed thinking

Thought Process					
☐	☐	☐	☐	☐	Hearing voices or seeing visions; mental confusion; odd beliefs; paranoia

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

Inattention/Hyperactivity					
☐	☐	☐	☐	☐	Hyperactive; impulsive; restless
☐	☐	☐	☐	☐	Inattentive, disorganization, forgetful, easily distress

Other problems not listed previously:

Child/Adolescent Strengths

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

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

Client Name:_____ Age:_____
Medicaid #/Member ID#:_____ Today's Date:_____
Person Completing form:_____ **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	
☐	☐	☐	☐	☐	Feeling so restless you couldn't sit still
☐	☐	☐	☐	☐	Being suddenly scared for no reason
☐	☐	☐	☐	☐	Feelings of worthlessness
☐	☐	☐	☐	☐	Feeling blue
☐	☐	☐	☐	☐	Spells of terror or panic
☐	☐	☐	☐	☐	Heavy feeling in arms or legs
☐	☐	☐	☐	☐	Feeling lonely
☐	☐	☐	☐	☐	Feeling tense or keyed up
☐	☐	☐	☐	☐	Feeling lonely even when you are with people
☐	☐	☐	☐	☐	Feeling afraid to go out of your home alone
☐	☐	☐	☐	☐	Feeling no interest in things
☐	☐	☐	☐	☐	Feeling fearful
☐	☐	☐	☐	☐	Feeling weak in parts of your body
☐	☐	☐	☐	☐	Nervousness or shakiness inside
☐	☐	☐	☐	☐	Feeling afraid in open spaces or on the streets

_____ _____
Clinician Signature Date

_____ _____
Adult Client or Guardian Signature Date

Please complete the following PCL-5 assessment if you have severe stress responses.

Name: _____

Date: _____

Last 4 SSN: _____

18 years old and up complete.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then check off one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all 0**	**A little Bit 1**	**Moderately 2**	**Quite a bit 3**	**Extremely 4**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	☐	☐	☐	☐	☐
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	☐	☐	☐	☐	☐
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	☐	☐	☐	☐	☐
15. Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16. Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17. Being “superalert” or watchful or on guard?	☐	☐	☐	☐	☐
18. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19. Having difficulty concentrating?	☐	☐	☐	☐	☐
20. Trouble falling or staying asleep?	☐	☐	☐	☐	☐

Score

Clinical Notes