



Consent For Services

Please read the Client Service Agreement Guide, which can be found on our website at:
<https://rivervalleybhwc.com/patient-forms/>

After reading the Client Service Agreement Guide, initial the required boxes.

- **Treatment (*please initial*):** _____
 - Consent For Treatment (check all that apply):
 - Therapy
 - Medication Management
 - Psychological Assessment
 - Minor
 - Adult
 - Safe Harbor and The Divorce & Custody Litigation Agreement.
 - Filled out (separate form) (*please initial*) _____
 - Not applicable (Adult Client)
 - I understand treatment is confidential; however, there are limits to confidentiality under the mandatory laws of Minnesota.
- **Financial Policy (*please initial*):** _____
 - I understand and agree with the Financial Policy of RVBHC (*initial*) _____
 - I am using my insurance (100% responsible for what they do not pay).
 - I am paying privately and/or not using my insurance (separate form).
 - Credit Card Information (**must have one on file in order for treatment at RVBHC.**)
 - **Copays and private pay are due at the time of service and credit cards will be run** unless other arrangements have been made with the billing department and approved before your visit.
 - If there is a balance before your next visit your card will be run on the 15th and 30th of each month (if these dates fall on a holiday or weekend, it will be run on the next business day).
 - I understand and agree to the late cancellation policy (*please initial*). _____
 - I give permission to the following person _____ to
 - Make or Cancel appointments
 - Have access to my financial information
 - Patient Portal and Newsletter (check all that apply):
 - Please sign me up for the patient portal
 - Please sign me up for RVBHC Newsletter
- **Client's Rights and Responsibilities reviewed (*please initial*).** _____

**Adult or Minor Consent to Treatment
Therapy, Assessment &/or Psychiatric Medication Management Services**

I, _____, adult client OR parent and/or guardian of _____ (minor client if applicable), hereby acknowledge that I have been given a copy of the River Valley Behavioral Health and Wellness Center Client Service Agreement. I have read and by signing below, I agree to all terms and conditions with the Service agreement along with the highlighted areas below.

Signature of adult client OR parent/legal guardian

Date

Signature of minor client (REQUIRED IF APPLICABLE)

Date

I have reviewed RVBHC's Client Service Agreement Guide and Consent with my client:

Provider's Signature

Date



Client Demographic Information

Client name: _____ Date of Birth: _____

Preferred Name (if any): _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Cell Home Business Messages - Yes No

Secondary Phone: _____ Cell Home Business Messages - Yes No

Email Address: _____

Gender: Male Female non-Binary

Pronouns: He/him/his She/her/hers They/them/theirs Other: _____

Race: White Black/African American American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander
 Hispanic Declined to specify

Marital Status: Married Single Widowed Divorced Legally separated Domestic partner

Employment Status: Employed Retired Disabled Student Not employed

Text Appointment Reminders? YES NO **THESE REMINDERS ARE COURTESY & NOT GUARANTEED. Text messages go out 2 days prior to the appointment, do not text back to confirm/cancel. If you need to cancel the appointment, please call prior to 24 hours of the appointment. (This excludes Saturdays, Sundays & holidays)*

EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____

Email: _____ Relationship: _____

LEGAL GUARDIAN

Is the Adult Client their own Legal Guardian? YES NO

If NO, please provide the guardian information below and provider River Valley Guardianship Paperwork.

Legal Guardian: _____ Phone: _____

Email: _____ Relationship: _____

RESPONSIBLE PARTIES

Responsible Party #1: _____ Date of Birth: _____

Responsible Party Address: _____ City: _____ State: _____ Zip: _____

Relation to Client: _____ Phone: _____

Responsible Party #2: _____ Date of Birth: _____

Responsible Party Address: _____ City: _____ State: _____ Zip: _____

Relation to Client: _____ Phone: _____

Pharmacy (Name): _____	Phone: _____
Address: _____	City: _____ State: _____
Phone: _____	Fax: _____

PRIMARY CARE COMMUNICATION

Would you like River Valley Behavioral Health and Wellness Center, LLC to communicate with your other health care providers? It is your right to either agree or disagree to this request. If you would not like information sent to your primary care physician's office, please indicate below. Release of Information Forms must be signed for each physician, psychiatrist or healthcare provider who will be contacted outside of River Valley.

- I agree to this request and would like for immediate contact between you and my primary care physician, psychiatrist, or nurse practitioner.
- I decline contact between you and my primary care physician at this time. Should something arise, I will complete a release of information form.

INSURANCE

Insurance Information/Private Pay: *ALL COPAYS, BALANCES AND PRIVATE PAY AMOUNTS ARE DUE IN FULL AT TIME OF SERVICE UNLESS AGREEMENT IS SET UP WITH BILLING DEPARTMENT

<p>PRIMARY INSURANCE COMPANY</p> <p>Name: _____</p> <p>Member ID#: _____</p> <p>Group #: _____</p>	<p>SECONDARY INSURANCE COMPANY</p> <p>Name: _____</p> <p>Member ID#: _____</p> <p>Group #: _____</p>
<p>Copay: _____</p> <p>Deductible: _____</p>	<p>Copay: _____</p> <p>Deductible: _____</p>

CREDIT CARD INFORMATION

It is a requirement to have a credit card on file with River Valley. If you want to use an HSA card you will need to have a credit card on file as a secondary payment form. Please review your service agreement for more information.

- I have given my credit/debit card information to River Valley BHWC Staff, and it has been saved in the secure and PCI compliant credit card processing service that River Valley BHWC operates with.

If you have not, please call [952-746-7664](tel:952-746-7664) to provide this information over the phone. It is directly entered into an encrypted credit card processing service which is very safe and secure as required by our bank. This is required to avoid your appointment(s) cancellation.

I hereby give consent to charge my credit card below for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me. All balances will be run the next day if balance is not paid at time of service.

Signature (Responsible Party): _____ **Date:** _____



RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER

Informed Consent for Telehealth Sessions

Telehealth allows my provider to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment. I hereby consent to participate in psychotherapy and or medication management services via the internet (hereinafter referred to as telehealth) with the clinician listed below:

Client: _____ Address: _____

Email: _____ Phone Number: _____

Emergency Contact: _____
Name & Relationship - Phone Number

I understand I have the following rights under this agreement:

- I have the right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy or medication management. Any information disclosed by me during the course of my session is generally confidential.
- There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and vulnerable adult abuse, and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such a mental or emotional condition to be a danger to myself or others, my provider has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent.
- I understand that while psychotherapy and medication management have been found to be effective in treating a wide range of mental disorders and personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.
- River Valley utilizes secure and reliable HIPAA compliant platforms as their primary telehealth and virtual care communication. I understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our sessions or other communication by my provider to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. In the event of disconnection, the provider will call the client at the phone number listed above to discuss rectifying technical issues or rescheduling the session. Telehealth sessions are not permitted by phone only.
- I understand that telehealth treatment is different from in-person therapy and medication management and that if my provider believes I would be better served by another form of psychotherapeutic or medication management services, such as in-person treatment, I will be referred to a provider in my geographic area for such services.

- I understand that some parts of the examination involving physical tests for medication services cannot be conducted during a telehealth session, and my provider may direct me to have these tests conducted by a professional at my location.
- I accept that telehealth does not provide emergency services. During our first Telehealth session, my provider will discuss an emergency response plan, which will include contacting the listed emergency contact and/or 911 for the address listed. If I am experiencing an emergency situation, I understand I can call 911 or proceed to the nearest hospital emergency room. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.
- I understand I am responsible for 1) providing the necessary computer, telecommunications equipment, and internet access for my telehealth sessions; 2) maintaining the information security on my computer; and 3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.
- I understand that I cannot be driving at the time of my session. If I am to take my telehealth session within my vehicle, I must be parked.
- I understand that it is my responsibility as the client to call my insurance company and ask if the benefits under my plan cover telehealth and telemedicine sessions.
- I understand that I must be present in the state of MN for my telehealth appointment. If I am outside of the state of MN during a scheduled telehealth appointment, the appointment will be cancelled and I may be charged the \$100 late cancel fee.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to telehealth communications by providing written notification to River Valley Behavioral Health & Wellness Center. My signature below indicates that I have read this Agreement and agree to its terms.

Client (or Guardian) Signature

Date

ADULT INTAKE FORM

Client Name: _____ DOB: _____

Please briefly describe your presenting concern(s). Which one or two would you rate the most concerning right now?

Please describe how the above is impacting your life right now: _____

Are there any recent stressor or changes in your life or is there anything else that you think might be important for your therapist to know? (Include abuse issues, moves, job loss or changes, divorce, illnesses, deaths, trauma, accidents, legal problems, drug, alcohol abuse in the family, or other major stressors)

How do you currently cope with stress (examples: social media, exercise, seek out friends, etc.)?

Goals you want to accomplish in therapy: _____

Mental Health History:

Have you been in therapy before? If yes, what did you like/dislike about your previous experience in therapy? How long?

Current Life Situation:

What language/languages do you speak? _____

What is the best way to describe your current living situation? Please list names, ages, and relationship to anyone living with you.

Do you have any pets? _____

What is your highest level of education and current job?

What are your hobbies/interests?

Medical & Mental Health History:

Who is your primary care physician? _____

When was you last physical exam? _____

Please explain any significant medical problems, symptoms, or illnesses:

Current Medications:

Name of Medications	Dosage	Purpose	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke or use tobacco? YES NO If yes, how much per day? _____

Do you consume caffeine? YES NO If yes, how much per day? _____

Do you drink alcohol? YES NO If yes, how much per day/week/month/year? _____

Do you use any non-prescription drugs? (Please remember that this form is completely confidential).

YES NO If yes, what kinds and how often? _____

Please list ANY family medical history concerns (relationship and concern)

- Drug/Alcohol Problems
- Legal Trouble
- Domestic Violence
- Suicide
- Other: _____

- Physical Abuse
- Sexual Abuse
- Hyperactivity
- Depression

- Anxiety
- Learning Disabilities
- Nervous Breakdown
- Psychiatric Hospitalization

Have you had any psychiatric or psychological evaluations done in the past? If so, please list.

Have you had prior hospitalization/in-patient treatment or residential care for psychiatric, emotional, or substance use disorder? Please answer yes or no. _____

Have you ever talked with a psychiatrist or other mental health professional? (Please list approximate dates and reasons):

Social History:

Current use of social media and time spent on the internet, snapchat, TikTok, or other forms of social media? How many hours a day? Is your use of social media impacting any of your relationships?

Where were you raised? _____

Marital status of your parents. Married, never married, separated, divorced? If divorced, what age were you?

How many siblings do you have? _____

Where you ever placed outside of your home as a child? Please answer yes or no. _____

Have you ever experienced trauma/abuse? If yes, please describe.

Do you have any legal history? If yes, please describe.

Have you ever received counseling for substance use? _____

Current Risk Assessment:

Do you currently feel safe in your home? If no, please describe if comfortable.

Do you have other safety concerns currently? If yes, please explain.

Please check all that apply:

Difficulty With:	Now	In the Past		Difficulty With:	Now	In the Past		Difficulty With:	Now	In the Past
Anxiety				Relationships (Home, work, school)				Head Injury		
Depression				Blackouts				Nausea		
Mood Changes				Marriage/Partner				Dizziness		
Anger/Temper				Employment				Shortness of Breath		
Panic Attacks				Finances				Sweating		
Fears				Legal Problems				Muscle Tension		
Irritability				Sexual Problems				Heart Palpitations		
Concentration/ Attention				Child Abuse				Pain		
Careless Mistakes				Sexual Abuse				Speaking without thinking		
Headaches				Domestic Violence				Completing Tasks		
Memory				Thoughts of Hurting Self				Impulse Control		
Excessive Worry				Thoughts of Hurting Others				Dangerous Behavior		
Hyperactivity				Thoughts of Suicide				Grief/Loss		
Trusting Others				Sleep Problems				Changes in Appetite/Weight Loss or Gain		
Drugs				Nightmares				Body Image		
Alcohol				Stress				Binging or Purging		
Self-injurious Behavior				Parenting				Distressing Thoughts		
Motivation				Obsessive Thinking				Delusions, Hallucinations (hearing/ seeing things)		
High/Low Energy				Intrusive Thoughts				Beliefs that you have special powers		
Loss of Interest				Gambling				Bizarre/Unusual Experiences		

This is a strictly confidential patient medical record.

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Date: _____ Name: _____ DOB: _____

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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (<i>add your column scores</i>) = _____				

If you checked off any problems, how difficult have these 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: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

WHODAS 2.0

Client Name: _____ DOB: _____

Instructions: This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please **choose only one** response.

In the past 30 days, how much difficulty did you have in:

Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme/cannot do
Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme/cannot do
Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme/cannot do
How much of a problem did you have joining in community activities (festivities, religious, or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme/cannot do
How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme/cannot do
Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme/cannot do
Walking a long distance such as a kilometer (equivalent to 0.62 miles)	None	Mild	Moderate	Severe	Extreme/cannot do
Washing your whole body?	None	Mild	Moderate	Severe	Extreme/cannot do
Getting dressed?	None	Mild	Moderate	Severe	Extreme/cannot do
Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme/cannot do
Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme/cannot do
Your day-to-day work?	None	Mild	Moderate	Severe	Extreme/cannot do

Overall, in the past 30 days, how many days were these difficulties present?	Record number of days _____
In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Record number of days _____
In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Record number of days _____