RIVER VALLEY
BEHAVIORAL HEALTH
& WELLNESS CENTER

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 RVBHWC (***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 RVBHWC).**
    - **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 RVBHWC 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 RVBHWC's Client Service Agreement Guide and Consent with my client:

_____ _____
Provider's Signature Date

RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER

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

PRIMARY INSURANCE COMPANY Name: _____ Member ID#: _____ Group #: _____	SECONDARY INSURANCE COMPANY Name: _____ Member ID#: _____ Group #: _____
Copay: _____ Deductible: _____	Copay: _____ Deductible: _____

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 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
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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

RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER

CHILD/ADOLESCENT INTAKE

CLIENT NAME: ____ DOB: ______________

To the best of your ability please answer the following questions for the patient that will be seen today:

1. Who has legal custody of the child or adolescent patient? (i.e. who can legally make medical decisions about the child's care) Please include appropriate supporting paperwork if necessary

____

____

2. Who lives in the household with the patient?

Name	Age	gender	Relationship to client
		M/F	
		M/F	
		M/F	
		M/F	
		M/F	

3. Please list **current** medications, supplements, and homeopathic remedies taken:

None

Name of Prescription:	*Dose* (mg, ml, etc.)	*Form* (tab, caps, etc.)	*Duration* (#times per day, wk, mo) –or-	chronic	Unknown
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____
____________	______	______	____x per ______	____	____

4. Is the child currently seeing a therapist? If so, provide name, location, and duration:

____

5. Who is the child's primary care physician? Please provide name and location:

____

6. Other Current or past Psychiatric Providers, if any:

_____

7. Please list **past** medications trialed (dose, directions, when started and stopped)

_____

_____

_____

_____

8. Any recent lab or test results? (what was tested, where, and results if known)

_____

_____

9. Any drug, food, or environmental allergies? ☐ Yes ☐ No, if yes please list:

_____

10. Any current or past medical conditions? _____

11. Any medical hospitalizations? _____

12. Past surgeries? ☐ Yes ☐ No, if yes please list:

_____

13. Has child seen any medical specialists such as cardiologists or neurologists? ☐ Yes ☐ No, if yes please list:

_____

14. Any family medical conditions (maternal or paternal):

_____

_____

_____

15. Any family mental health or substance use history? _____

Review of Current Symptoms

*Please check any **current** symptom*

General/Constitutional-
- ❑ Good general health lately
- ❑ Weight loss or gain
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever or chills
- ❑ Weakness
- ❑ Trouble sleeping

Skin-
- ❑ Itching
- ❑ Rashes
- ❑ Dryness
- ❑ Color changes
- ❑ Hair/nail changes

Head & Neck-
- ❑ Headache
- ❑ Head injury
- ❑ Neck Pain
- ❑ Swollen glands
- ❑ Pain
- ❑ Stiffness

Eyes-
- ❑ Vision Loss/Changes
- ❑ Glasses/Contacts
- ❑ Blurry/double vision
- ❑ Irritation
- ❑ Drainage

Hematologic-
- ❑ Bruise easily
- ❑ Unexplained lumps

Cardiovascular-
- ❑ Chest pain
- ❑ Tightness
- ❑ Palpitations

Endocrine-
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Excessive sweating
- ❑ Excessive urination
- ❑ Excessive thirst

ENT-
- ❑ Difficulty swallowing
- ❑ Ringing in ears
- ❑ Nosebleeds
- ❑ Sore/scratchy throat
- ❑ Change in voice
- ❑ Stuffy nose
- ❑ Itchy eyes
- ❑ Sneezing

Respiratory-
- ❑ Cough
- ❑ Shortness of breath
- ❑ Congestion
- ❑ Wheezing

Gastrointestinal-
- ❑ Nausea
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Vomiting
- ❑ Blood in stool

Urinary-
- ❑ Frequency
- ❑ Urgency
- ❑ Burning or pain
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Difficulty urinating

Musculoskeletal-
- ❑ Muscle or joint pain
- ❑ Back pain
- ❑ Muscle aches
- ❑ Leg cramps
- ❑ Stiffness
- ❑ Joint swelling

Neurologic-
- ❑ Seizures
- ❑ Weakness
- ❑ Numbness
- ❑ Tingling
- ❑ Tremor
- ❑ Dizziness
- ❑ Fainting

Other symptoms:

_____

_____

_____

_____

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*** _____