WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

HONESDALE BEHAVIORAL HEALTH OFFICE

NOTICE OF NEW POLICY REGARDING PATIENT APPOINTMENTS

PLEASE BE ADVISED THAT DUE TO THE OVERWHELMING DEMAND FOR APPOINTMENTS IN OUR HONESDALE OFFICE, WE ARE IMPLEMENTING THE FOLLOWING NEW POLICY:

IF YOU "NO SHOW" FOR THREE MEDICATION APPOINTMENTS IN 1 YEAR OR 2 THERAPY APPOINTMENTS IN 1 YEAR:

("NO SHOW" MEANS YOU DON'T CALL TO CANCEL OR RESCHEDULE AND DON'T COME TO YOUR APPOINTMENT)

1. **YOU WILL NO LONGER BE ABLE TO BOOK ANY APPOINTMENTS IN ADVANCE, AND WILL ONLY BE ABLE TO CALL IN ON A GIVEN DAY, TO BE PLACED ON A CANCELLATION LIST FOR THAT DAY ONLY.**

2. **IF YOU NO SHOW REGULARLY, THE PROVIDERS RESERVE THE RIGHT TO DISMISS YOU COMPLETELY FROM THE PRACTICE.**

3. **IF YOU ARE DUE FOR A FOLLOW-UP APPOINTMENT, THE PROVIDERS WILL NOT FILL YOUR MEDICATIONS UNTIL YOU ARE SEEN, SO YOU WILL NOT BE GRANTED REFILLS OVER THE PHONE IF YOU MISS YOUR APPOINTMENT.**

4. **PLEASE ALSO BE ADVISED, THAT IF YOU ARRIVE MORE THAN 10 MINUTES LATE FOR YOUR DOCTOR'S APPOINTMENT, OR 15 MINUTES LATE TO YOUR THERAPY SESSION, WE RESERVE THE RIGHT TO CANCEL YOUR APPOINTMENT AND RESCHEDULE IT.**

IF YOU ARE CANCELLING YOUR APPOINTMENT, PLEASE BE COURTEOUS TO OTHERS AND CALL AT LEAST 24 HOURS AHEAD, SO WE CAN FILL YOUR SPOT WITH SOMEONE ON THE WAITING LIST

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
BEHAVIORAL HEALTH PRACTICES
MEDICATION GUIDELINES

WE DO NOT PRESCRIBE MEDICAL MARIJUANA.

The WMCHC Behavioral Health Practices will not prescribe Xanax.

If a patient is prescribed a controlled substance, the provider may order a urine drug screen or pill count at their discretion.

The WMCHC Behavioral Health Practices will not prescribe immediate release stimulants to adults.

The WMCHC Behavioral Health Practices will not prescribe benzodiazepines to any patient who may be taking them in combination with opioids and/or stimulants and/or recreational substances.

Controlled substance prescriptions that are lost or stolen will not be replaced, under any circumstances.

Controlled substance prescriptions will not be refilled early, under any circumstances.

Complaints regarding medication abuse will result in periodic random urine drug screening without prior notice, for a period of at least 3 months or longer and/or random pill counts, at the discretion of the provider or, could result in discharge.

Evidence of manipulating a controlled substance prescription or selling prescribed medications is a felony and will result in discharge from the practice and a report to the Attorney General.

Any abusive/threatening behavior by patients will result in immediate discharge from the practice.

The Behavioral Health Practices of Wayne Memorial Community Health Centers seek to provide services in a professional, compassionate and respectful manner. WMCHC requires the same respect from patients when interacting with providers and staff.

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

DEMOGRAPHICS

DATE _____ FIRST NAME_____MIDDLE _____ LAST NAME _____

DATE OF BIRTH _____ MARITAL STATUS: _____ PRIOR LAST NAME _____

ADDRESS: _____ SOCIAL SECURITY # _____

_____ SEX: Male Female

PRIMARY PHONE: (_____)_____ SECONDARY PHONE: (_____)_____

Circle one: Home Cell Work Other:_____

☐ OK to leave a message with detailed information

☐ Leave call back number ONLY

Circle one: Home Cell Work Other:_____

☐ OK to leave a message with detailed information

☐ Leave call back number ONLY

EMAIL:_____

INSURANCE

INSURANCE INFORMATION-PLEASE PROVIDE CARD

PATIENT WILL BE CONSIDERED A SELF-PAY ACCOUNT UNTIL INFORMATION IS PROVIDED

*** * GUARANTOR IS THE PERSON FINANCIALY RESPONSIBLE FOR BALANCES. * ***

IF OTHER THAN THE PATIENT PLEASE PROVIDE REQUIRED INFORMATION:

GUARANTOR IS: PATIENT OTHER _____

ADDRESS: _____ DATE OF BIRTH _____

SOCIAL SECURITY #_____ TELEPHONE # OF GUARANTOR: _____

PHARMACY

PHARMACY PREFERENCE_____ PHONE # (_____)_____

CITY/STATE _____

MISCELLANEOUS

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____

TELEPHONE # (_____)_____

IF MINOR CHILD – NAME OF PARENT OR GUARDIAN: _____

PRIMARY CARE PHYSICIAN: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

SIGNATURE

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Relationship: _____ Date: _____

PAYMENT: We accept cash, checks and credit cards. Payment is due upon receipt of medical services. Co-payments must be paid at the time of your visit. If financial arrangements are needed, please notify the receptionist, as approval will be needed before your visit.

Voluntary Confidential Information

Why are we asking for this information? WMCHC develops and expands services in our community utilizing federal grant funds. Collection of the information below allows us to access grant funds bringing more health care services and health care jobs to our area. Your help in obtaining this information is greatly appreciated. **These statistics are reported to the government in total not by individual name.** We would like you to fill out the form completely but understand if there are questions you do not want to answer. **Thank You.**

1) What is your primary language?
- ☐ English
- ☐ Non-English
- ☐ Deaf/Sign Language
- ☐ Interpreter Required

2) Sex at Birth:
- ☐ Male
- ☐ Female

3) Sexual Orientation: ☐ Choose not to disclose
- ☐ Straight or heterosexual
- ☐ Lesbian /Gay
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't know

4) Gender Identity: ☐ Choose not to disclose
- ☐ Male
- ☐ Female
- ☐ Transgender Male/ Female-to-Male
- ☐ Transgender Female/ Male-to-Female
- ☐ Other

5) Ethnicity: ☐ Choose not to disclose
Hispanic or Latino ☐ Yes ☐ No

6) Race: ☐ Choose not to disclose
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ White/Caucasian
- ☐ More than one race

7) Insurance:
- ☐ Chip
- ☐ Medicaid (Access includes Access HMO)
- ☐ Medicare (including Medicare replacement)
- ☐ Dual Eligible (Medicare/Medicaid)
- ☐ Self Pay
- ☐ Commercial (Aetna, Highmark, GHP, Unions)
- ☐ Other_____

8) Income Range: (Total Family Income) ☐ Choose not to disclose

Family Size: _____ (Number of dependents, including yourself and spouse)

If you do not wish to report your family income, please mark ☐ (Choose not to disclose). Thank you.
- ☐ $0-$10,999
- ☐ $11,000-20,999
- ☐ $21,000-$30, 999
- ☐ $31,000-$40, 999
- ☐ $41,000-$50, 999
- ☐ $51,000-$60, 999
- ☐ $61,000-$70, 999
- ☐ $71,000-$80, 999
- ☐ $81,000-$90, 999
- ☐ $91,000-$100, 999
- ☐ $101,000 and above

Are you a dependent? ☐ Yes ☐ No

9) Please check any of the following that apply:

Are you a veteran of the armed services?	☐ Yes	☐ No
Migrant Agricultural Worker	☐ Yes	☐ No
Seasonal Agricultural Worker	☐ Yes	☐ No

10) Homeless ☐ Yes ☐ No (Definition of a homeless person- person who lack housing. This includes persons living with friends & relatives- doubling up.)
Please define type of Homeless
☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street

Reduced Fees:
☐ Yes, I would like to be contacted about the sliding fee program.
☐ No, I would not like to be contacted about the sliding fee program.

WAYNE MEMORIAL
COMMUNITY HEALTH
CENTERS
600 Maple Ave. Honesdale, PA 18431
(570) 253-8219 (phone) ~ (570) 253-8242 (fax)

Wayne Memorial Behavioral Health

Authorization for Disclosure of Behavioral Health Information

Patient Name:_____ Date of Birth: _____

Social Security Number: _____Medical Record Number: _____

I hereby authorize the use of disclosure of the above – named individual's health information as described below.

Patient's Primary Phone: (_____) _____ - _____

☐ OK to leave a message with detailed information
☐ Leave call back number ONLY

Persons/Organization to provide information:

Wayne Memorial CHC
Behavioral Health
600 Maple Ave. Suite 6
Honesdale, PA 18431

Persons/Organization to receive information:

Name: _____
Relationship: _____
Address: _____
_____

Phone (____) _____ - _____

☐ OK to leave a message with detailed information
☐ Leave call back number ONLY

Phone (____) _____ - _____

☐ OK to leave a message with detailed information
☐ Leave call back number ONLY

Specific description of information to be disclosed (include date(s)): _____

_____

Purpose for disclosing information: _____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand that if the organization / individual authorized to receive the information is not a health plan or health care provider: the released information may no longer be protected by federal privacy regulations.

Unless otherwise revoked, this authorization will expire 365 days from the date of signature. I understand that my health care and the payment of my health care will not be affected if I do not authorize this disclosure. I understand that I will be given a copy of this authorization form, after signing. I understand the information in the paragraph above, and, I agree to the release of information from my behavioral health record to the recipient noted.

_____ _____

Signature of Patient / Legal Guardian **Date**

If signed by legal representative, relationship to patient _____

_____ _____

Signature of Witness **Date**

Patient is physically unable to sign consent form. Verbal consent to release the information specified about was obtained from

_____ on _____ at _____.

(Patient Name) (Date) (Time)

Patient verbalized that she/he understands the nature of the release and freely gives consent to the release of information from her/his behavioral health record to the recipient noted.

_____ _____ _____ _____

Signature of Witness to Verbal Consent Date Signature of Witness to Verbal Consent Date

WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
BEHAVIORAL HEALTH

600 MAPLE AVENUE
HONESDALE, PA 18431
(P) 570-253-8219 (F) 570-253-8242

INSTRUCTIONS TO PATIENT Please complete this form. It will provide us with important information about you and your needs.

Patient Name _____ **Date** _____

Birthdate: _____ **Age** _____

REASONS FOR SCHEDULING AN APPOINTMENT:

HOUSEHOLD & RELATIONSHIPS

LIST WHO LIVES IN YOUR HOME:

NAME	SEX	AGE	RELATIONSHIP TO YOU

List the occupations of yourself and the other adults who live in the home and how many hours worked outside the home at each job per week. If you are a student, include your time at school plus any jobs:

First Name Occupation Hours worked/week (average)

How long have you lived at this location?

FAMILY / OTHER IMPORTANT RELATIONSHIPS Please note marital status, past marriages, divorces, dating and relationships. Describe degree of support received from family, friends, school, support groups and others.

FAMILY OF ORIGIN: Please describe your relationships with parents/caregivers and brothers/sisters.

PATIENT HEALTH INFORMATION:

ALLERGIES:
Medication Allergies: None ___ Yes: List _____
Other allergies: None ____ Yes : List: _____

PHYSICIANS:
Family MD or Pediatrician: _____
Date of last physical: _____
List any specialists you see: _____

MEDICATIONS: Please list all current medications; both prescription and over the counter taken on a regular basis.

Medication _____ Dosage _____ Reason

MEDICAL CONDITIONS: List all medical problems and indicate if past or current:
Condition _____ Past _____ Current:

PHYSICAL HANDICAPS OR CHALLENGES: (visual, hearing, motor, physical, etc.) None ____ Yes: Describe:

SLEEP: -Average hours of sleep per night? _____ I sleep: Soundly ___ Fitfully or Restlessly ___
I have bad dreams: Never ___ Occasionally ___ Frequently ___
Do you have concerns about sleep or bedtime? No ___ Yes ___ Describe:

FEMALE HEALTH: Not applicable ___
Is menstruation: Regular ___ painful ___ irregular ___ No periods for ____ months
Do you think there are excessive signs of PMS? No ___ Yes ___
Comments:

Number of Pregnancies: _____ Number of Deliveries: _____

NUTRITION: Appetite is usually: Good ___ Excessive ___ Poor ___ Variable ___
My weight over the past few months: has been constant at _____lbs
Gone up by _____lbs
Gone down by _____Lbs
Do you think about your weight and how you look a lot? No ____ Yes ____
Do you have any concerns about your eating patterns or nutrition? No ___ Yes ___
Do you have any difficulty with eating or swallowing? No ____ Yes ____.
Is there history of vomiting, bingeing or excessive preoccupation with food? No ____ Yes ___
Comments:

SEXUAL: Do you have any sexual or sexuality concerns? No ____ Yes ____ Comments:

TOBACCO: Do you smoke or use Tobacco? No _____ Yes _____
DRUGS & ALCOHOL: Do you use/abuse alcohol? No ___ Yes ____
Do you use/abuse drugs/illegal substances? No ____ Yes ____ Comments:

VIOLENCE / ABUSE: Please describe any physical, verbal, emotional or sexual abuse as the perpetuator, victim or witness. Was the abuse reported to the authorities?

FAMILY MEDICAL HISTORY: List the relationship of the family member and any details if applicable:
List any significant medical problems in the immediate family or close relatives? None ____ Comments:

List any history of genetic illness or developmental illnesses (mental retardation, autism, Huntington's Chorea, Sickle Cell, etc)?: None ____ Comments:

List any family history of emotional problems (nervous breakdowns, depression, obsessive/compulsive, anxiety, schizophrenia, bipolar, etc)? No ____ Comments:

List any family history of suicide? None ____ Comments:

List any family history of substance abuse or addictions? None ____ Comments:

PAST COUNSELING AND PSYCHIATRIC TREATMENT:
List any inpatient hospitalizations: None ___ Comments:

List any partial hospitalizations or Intensive Outpatient Treatment (IOP): None ____ Comments:

List any previous counseling with provider and date: None _____ Comments:

List any medicines used in the past for emotional or behavioral problems: None ____ Comments:

SOCIAL HISTORY:
EDUCATION Provide level of schooling completed, feelings about school, and grades. Please note any discipline problems or learning difficulties. Also, please indicate how you prefer to learn (for example: reading, practicing, talking or watching).

EMPLOYMENT: Provide work history, retirement, terminations, problems on the job, EAP involvement, relationships with co-workers and bosses, shifts, hours per week.
☐ Not Applicable **Military:** ☐ Yes ☐ No ☐ Not Applicable

LEGAL HISTORY: Note any legal difficulties including arrests, nature of charges, convictions, pending charges, guardianship, power of attorney. If you have a probation/parole officer, please provide name and phone number.

CULTURAL: Please describe your ethnic background, religion, community and customs. Please list any cultural issues/practices you would like us to be aware of that would affect your treatment or that you wish to discuss further:

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SUICIDAL/HOMICIDAL IDEATION	
Have you ever done something on purpose *with the intention* of killing yourself?	☐ yes ☐ no
If YES, how many times and when?	
What method / methods did you use?	
Have you ever done anything to hurt or inflict pain on yourself (cutting, scratching, burning, etc) *without* the intention of killing yourself?	
☐ yes ☐ no If YES, please explain.	
Do you CURRENTLY feel that you'd be better off dead, or that others would be better off if you were dead?	☐ yes ☐ no
Have you been thinking about killing yourself recently?	☐ yes ☐ no

GENERAL PSYCHIATRIC SYMPTOMS AND RELEVANT FACTORS	
Have you ever been physically abused?	☐ yes ☐ no
Have you ever been sexually abused?	☐ yes ☐ no
Have you experienced other severe trauma in the past?	☐ yes ☐ no
Have you experienced missing blocks of time, even when not using alcohol or drugs?	☐ yes ☐ no
Have you recently lost interest in things you normally enjoy?	☐ yes ☐ no
Have you been feeling guilty without any real reason?	☐ yes ☐ no
Have you recently been crying more than usual?	☐ yes ☐ no
Have you recently had difficulty concentrating?	☐ yes ☐ no
Have you recently had problems with your memory?	☐ yes ☐ no
Does anxiety make it hard for you to do simple things most people do without a second thought?	☐ yes ☐ no
Do you feel "stressed out" most of the time?	☐ yes ☐ no
Do you feel anxious just talking to other people?	☐ yes ☐ no
Do you have "panic attacks"?	☐ yes ☐ no
Have you ever heard voices that other people don't hear?	☐ yes ☐ no
Have you ever felt you had "special powers" that other people don't have?	☐ yes ☐ no
Do you ever find you have boundless energy, so much that you don't need to sleep for days?	☐ yes ☐ no
Are you often in such a good mood that people think there is something wrong with you?	☐ yes ☐ no
Do you often feel compelled to do things repeatedly, such as counting or checking, even when you know there is no real reason to do so?	☐ yes ☐ no
Are you disturbed by repetitive thoughts that you find offensive or bothersome?	☐ yes ☐ no
Do you get "caught up" in certain patterns of thought or behavior that take up a lot of time, and interfere with your life?	☐ yes ☐ no
Do you frequently "binge" on food, that is, eat to the point of discomfort?	☐ yes ☐ no

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Alcohol:	Do you drink alcohol?		☐ yes ☐ no
	If yes, how many drinks per day, or per week?		
	At what age did you begin drinking?		
	Are you concerned about the amount you drink?		☐ yes ☐ no
	Is anyone else concerned about the amount you drink?		☐ yes ☐ no
	Have you considered stopping?		☐ yes ☐ no
	Have you experienced blackouts?		☐ yes ☐ no
	Have you experienced alcohol withdrawal?		☐ yes ☐ no
	Are you prone to "binge" drinking?		☐ yes ☐ no
	Do you drive after drinking?		☐ yes ☐ no
	If you are in recovery, how long have you abstained from alcohol (been alcohol-free)?		
	If you are in recovery, do you "work a program" or attend AA?		☐ yes ☐ no
	How many meetings a week do you attend?		
Tobacco:	Do you use tobacco?		☐ yes ☐ no
	Cigarettes (packs per day)	Chew (how many per day)	Pipe (how many per day)
	How many years?	Or year quit:	
Drugs:	Do you now, or have you ever used recreational or street drugs? (please describe below)		☐ yes ☐ no
	Now:		
	Past:		
	Have you ever given yourself street drugs with a needle?		☐ yes ☐ no
	If you are in recovery, how long have you been drug-free?		
	If you are in recovery, do you "work a program" or attend NA?		☐ yes ☐ no
	How many meetings a week do you attend?		

Have you ever been to Detox? Please state when and where, and for what substance.	☐ yes ☐ no
Have you ever been to Rehab? Please state when and where, and for what substance.	☐ yes ☐ no
Have you ever been to a mandated Chemical Dependency program? Please state when and where.	☐ yes ☐ no
Have you ever gotten a DUI?	☐ yes ☐ no

FINANCIAL STATUS: Please describe past and present credit history.

- ☐ Financially secure
- ☐ Finances are a source of stress
- ☐ Currently in debt
- ☐ Plan to file bankruptcy
- ☐ Have filed bankruptcy
- ☐ On Disability
- ☐ On Public Assistance

Comments:

LEISURE ACTIVITIES / TIME WITH OTHERS: Describe your hobbies, interests, social life and volunteer work.

Losses & Changes: What losses, changes or other stressors do you think are affecting you at this time?

OTHER: Is there anything else you would like to tell us?

Form completed by: Name _____ **Date:** _____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

The Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) by Mary C. Zanarini, EdD is a brief clinician administered interview to assess severity and change in BPD symptoms. To score - count the number of yes's. A score of 8 or more is indicative of a diagnosis of Borderline Personality Disorder.

1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups? Yes___No___

2. Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? Yes___No___

3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)? Yes___No___

4. Have you been extremely moody? Yes___No___

5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? Yes___No___

6. Have you often been distrustful of other people? Yes___No___

7. Have you frequently felt unreal or as if things around you were unreal? Yes___No___

8. Have you chronically felt empty? Yes___No___

9. Have you often felt that you had no idea of who you are or that you have no identity? Yes___No___

10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? Yes___No___