Desert Wise, LLC • 1201 Eubank Blvd NE, Ste. 1 • Albuquerque, NM 87112

Privacy Policy: Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Summary

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

By signing below, I affirm that I have read and understood Desert Wise's Privacy Policy, as summarized above. Further, I affirm that I have been given an opportunity to ask questions and have been provided a copy of Desert Wise's three-page detailed Privacy Policy.

Printed Name: _____ Date: _____

Signature: _____

Desert Wise's Detailed Privacy Policy

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get a paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/ .**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.*
- *We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html **.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html .

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Desert Wise Privacy Notices

Effective Date of this Notice: June 5, 2017

Desert Wise, LLC privacy official: Dr. Joye L. Henrie (505) 361-1957

Special notes that apply to Desert Wise's privacy practices

- We never market or sell personal information.

Desert Wise, LLC is part of an OHCA (Organized Health Care Arrangement) that includes co-located mental health entities. Within the OHCA, Desert Wise providers will consult with other OHCA providers with the purpose of providing you the best care. The other OHCA providers are also committed to your privacy and comply with the same privacy policies described above. Other involvement of the OHCA providers will include: (1) access to a collectively owned, shared waitlist of patients and (2) access to basic contact information for patients, so that patients may be notified of provider-initiated cancelations in the event of an emergency.

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Informed Consent

You can expect the attention, respect, and best professional efforts of your MH provider. Your MH provider will treat you as a responsible individual and will expect you to take an active role in your treatment. You should understand the goals and direction therapy is taking, and if you do not understand, you should ask. To better equip you to start treatment and understand some ground rules, the information below is provided:

To schedule follow-ups or cancel appointments, you can reach Desert Wise by calling 505-361-1957.

Limits to Services

Desert Wise does **not** provide MH emergency services, does **not** accept walk-in patients, and is **not** available for 24/7 consultation. If you have a MH emergency, you should immediately go to the nearest emergency room or call 911.

Confidentiality/Disclosure Policy Exceptions

- Danger to Self or Others. Providers must take steps to protect individuals from harm when a patient presents a serious threat to the life or safety of self or others. This can include (but is not limited to): notification to law enforcement in the event you intend to harm yourself or someone else or notification to your emergency contact if you may be too impaired to drive safely.
- Abuse to a Vulnerable Population. Providers must report suspected child abuse/neglect, suspected elder abuse/neglect, and/or suspected abuse or neglect to any other vulnerable population (e.g., disabled individuals) to relevant protective authorities and/or law enforcement.
- Court Order or Other Lawful Demand. Providers must obey court orders (e.g., subpoenas) and other lawful demands requiring release of records.

Records of Your Care

Each of your clinical visits to Desert Wise are documented in your medical record. Generally, only your primary MH provider is allowed to view these sensitive records. (See Confidentiality section, as well as Desert Wise's Privacy Policy for additional information.) After you terminate care at Desert Wise, your MH record will be maintained at Desert Wise and will permanently be subject to the privacy practices outlined in Desert Wise's Privacy Policy. The American Psychological Association (APA, 2008) requires that records are maintained in their entirety for 7 years after the last date of service or 3 years after a minor patient reaches majority age. Records will be disposed of confidentially and in accordance with state and federal law.

Disclosure Policy for All Patients

The privacy of patients is protected by the Federal Privacy Act. Your health information may be used or disclosed for treatment, payment, insurance operations, and health care operations. Most other information related to the treatment of patients is not releasable without the written consent of the patient. (See Confidentiality section, as well as Desert Wise's Privacy Policy for additional information.) Excluded from consent requirements are such activities as quality assurance reviews by other MH professionals operating in conjunction with Desert Wise's OHCA (Organized Health Care Arrangement) and quality assurance reviews by your insurance company's credentialing and quality departments. You have the right to request restriction of uses and disclosure of your protected health information by submitting this request in writing. Desert Wise will inform you of whether your provider agrees to this request.

Appointment Cancellation, No-Show, and Disengagement Policy for All Patients

Please give us at least 24 hours' notice if you will be unable to make an appointment with Desert Wise, as we make an effort to maximize our availability to patients awaiting care. If you provide less than 24 hours' notice, we will designate the appointment as a "no-show." If you have not arrived by 15 minutes after the scheduled start of your appointment time, we will designate the appointment as a "no-show." The fee for a no-show is $50, which is **not** covered by your insurance and will be billed directly to the credit card you have provided on file. If no-shows become a pattern, your provider may speak to you about whether continuing treatment makes sense for you at this time. If your provider has not heard from you for 30 or more days, your case will be closed. If you decide to reengage with treatment at a later date, you may have to be entered onto the waitlist. Case closure does not limit you from receiving services from other mental health professionals.

Telephone Communication

Face-to-face treatment is always the preferred method of communication. Telephone consultations are only considered on a case-by-case basis. When approved by your provider, telephone consultations are intended to assist in, not replace, the routine care you receive in our clinic.

Electronic Communication

You may have access to your provider's email address via business cards, websites, etc. This email is **not** to be used for clinical concerns and should **only** be used for brief, non-sensitive updates, such as canceling appointments. Do **not** email your provider regarding crises, emergencies, or the content of your MH sessions. Use of this method of communication is conducted at your own risk, as Desert Wise cannot assure the privacy, protection, or integrity of this form of communication. Emails sent to your provider become part of your legal MH record. Additionally, your provider may occasionally use a fax machine to transmit records (e.g., when you request that your primary care doctor receive updates). Your provider will take every reasonable precaution to protect your privacy, following all regulations and guidance outline by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Public Law 104-191), when using this form of communication, but your provider cannot guarantee the privacy practices of the recipient of the faxed document.

Internet and Social Media Policy

Your provider does not knowingly accept friend or contact requests from current or former patients on any social networking site, as these internet contacts can compromise your confidentiality, erode the privacy of your provider, and blur the boundaries of the therapeutic relationship. Do not use text messaging or messaging on social networking sites in an attempt to contact your provider.

Revocation of Consent

You have the right to revoke this consent in writing. However, actions taken by Desert Wise prior to revocation of the consent are not subject to the revocation.

Special Notes for Military-Affiliated Individuals

Despite Desert Wise's specialty in providing MH services to military members, Desert Wise's providers are not agents or employees of the DoD or federal government. Thus, the only disclosures made to your chain of command will be those expressly outlined in the Privacy Act and/or those you have authorized. However, the referring Medical Treatment Facility (MTF) has the right to request copies of your progress notes without your written consent, and as an authorized entity that bills TRICARE, Desert Wise is obligated to comply with these record requests. If you have concerns about Desert Wise releasing requested records to the MTF, please speak with your provider. Note: Since Desert Wise is not an entity of the DoD or federal government, your provider does not have the capability of issuing DLCs/profiles or writing NARSUMs for MEBs.

Special Notes for UNM Medical Residents

Given the nature of fitness for duty evaluations, there is no implied or expressed confidentiality as it pertains to the findings or recommendations derived from the evaluation. While Desert Wise is committed to providing the least amount of personal information necessary to accomplish communication of recommendations to UNM and/or its departments, residents agree that Desert Wise and its associated providers can relay recommendations, functional limitations, and the impairment level of the resident to UNM and/or its departments.

If you have any questions or concerns about the information and instructions contained herein, speak to your provider immediately.

By signing below, I affirm that I have read the policy above and voluntarily consent to evaluation and/or treatment with understanding of the limitations of my privacy.

Patient's Printed Name: _____ Signature:_____ Date:_____

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Telehealth and Technology Informed Consent

Telehealth (also called distance counseling, telepsychology, telemental health, or online therapy) is counseling using electronic, telephone, or visual telecommunications.

Telehealth Options Offered & My Privacy: I, the patient, understand that Desert Wise currently offers distance counseling via phone and visual telecommunication on a case-by-case basis. I understand that telehealth has limitations and is not intended to replace the routine care you receive in our clinic. Desert Wise offers visual telecommunication via Zoom and Skype. I fully understand that Zoom and Skype are not a guaranteed format for patient confidentiality and may not be a HIPAA (Health Insurance Portability and Accountability Act of 1996)-certified method of communication. I understand that Desert Wise offers distance counseling via phone sessions and that telephone communications are not a guaranteed format for patient confidentiality and is not a HIPAA-certified method of communication. I understand that I have the option to choose which method I prefer. I understand that I assume the risk of utilizing methods of communication that are not HIPAA-certified. I understand that, unless otherwise agreed upon, Desert Wise will not record my visual or phone sessions.

Technology Failure: I, the patient, do understand that in the event of a technology failure during a phone or visual telecommunication session, my provider will immediately attempt to reconnect. If I cannot be reached after three reconnection attempts (via the phone or visual telecommunication method being used for the session), my provider will contact me via email (if I have given Desert Wise permission to email me). If all attempts to reconnect fail, I agree that I will attend my next regularly scheduled session for follow-up.

Emergencies & Crisis: I understand that Desert Wise does not provide emergency mental healthcare, as outlined in the general *Informed Consent (DW-002)* that I agreed to and signed at the onset of my treatment. I understand that in the event of a psychological emergency, I am to call 911 or present to the nearest emergency room, and I agree to this plan.

Telehealth Using Visual Telecommunication:
____I give my consent to use Zoom for my distance counseling.
____I give my consent to use Skype for my distance counseling.

Telehealth Using Phone:
____I give my consent to use the telephone for my distance counseling.

I, the patient, have received, reviewed, and had ample opportunity to discuss Desert Wise's *Telehealth and Technology Informed Consent*, general *Informed Consent*, and *Privacy Policy*. I agree that:

- I will comply with the above emergency and crisis plan.
- I have opted in for the technology that is acceptable to me at this time (i.e., by initialing above).
- I have had ample opportunity to ask questions and receive clarification about these options and this policy.
- I have the option to change my mind about any of my choices listed above, and I will do so in writing.
- I recognize the potential risk of compromise to my confidentiality by using phone or visual telecommunication.
- I wish to proceed knowing these risks.
- This telehealth-specific informed consent does not modify, replace, or invalidate the general *Informed Consent (DW-002)* I signed at treatment onset.

By signing below, I affirm that I have read the policy above and voluntarily consent to evaluation and/or treatment, as described above, with understanding of the limitations of my privacy.

Patient's Printed Name: _____ Signature:_____ Date:_____

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Financial Agreement and Credit Card Authorization Form

Patient Name: _____ Today's Date: _____

I understand that I am responsible for understanding the mental health benefits of my insurance plan and for obtaining the necessary authorizations and referrals. In addition, I agree that my financial responsibilities include the following:
[**Please initial each section and sign at bottom of the document].**

_____ Payment of $50 for no-shows (i.e., missed appointments without 24-hour advance cancelation). *(The 24-hours does not include weekends. Cancelations are to be completed **24 business hours** prior to appointment time.)* **I understand that my insurance will not cover missed appointments.** This charge is the responsibility of the patient and must be paid in full before future appointments will be scheduled.

_____ Finance charge of 1.5% for accounts not paid in full within 60 days of the date of service

_____ Service charge of $25 each for returned checks, credit card chargebacks, and ACH/electronic bank rejections

_____ Patients paying by insurance:
Co-pays and deductibles are due at the time of service and will be charged to your credit card on file, unless you provide alternate payment at the time of service.

_____ Patients paying directly and/or patients whose insurance does not cover their mental health claims:
Payment is due at the time of service, at the following rates – plus 7.5% tax:
- $275 per initial intake session (45 – 90 minutes)
- $200 per 60 min therapy session (53 – 65 minutes)
- $175 per 45 min therapy session (38 – 52 minutes)
- $125 per 30 min therapy session (16 – 37 minutes)
- $250 per hour for other services such as letters in which clinical information is discussed, communication with other professionals, and services provided by telephone

_____ Desert Wise is committed to reducing waste and inefficiency through making our billing process as simple and easy as possible. We require that all patients maintain a valid credit card on file with our office.

Credit Card Type:	□ Visa □ MasterCard □ Discover □ American Express		
Cardholder Name: *(Exactly as it appears on card)*		**Expiration Date:**	
Credit Card Number:		**Security/CV Code on Back of Card:**	
Cardholder Billing Address:			
By signing below, I authorize Desert Wise, LLC to keep my signature on file and to charge my credit card for services rendered by Desert Wise, LLC and its staff, as well as other charges (e.g., no shows, as defined above) billed to my credit card according to the fee schedule and policies presented above.			
Cardholder Signature:		**Date:**	

_____ I agree not to dispute charges for sessions I have received or that I have not canceled 24-business-hours prior to a scheduled session. I further authorize Desert Wise, LLC to disclose information about my attendance/cancelation to my credit card issuer if I dispute the charge.

_____ Past due/overdue accounts may be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling or attending additional appointments.

_____ Informed Consent: I have been provided with, read, and agreed to Desert Wise's Privacy Policy (*DW-001*) and Informed Consent (*DW-002*) prior to signing this document (i.e., Financial Agreement and Credit Card Authorization Form).

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date

Insurance Information:
For those seeking insurance payment for services, complete the following section. *(Direct payers skip the rest.)*

Insurance Company:			
Plan Name:		Group Number:	
Policy Holder's Name:		ID Number:	
Policy Holder's Employer:			

Insurance Billing:

_____ We are happy to file a claim to your primary insurance company as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. Any amount not covered by your insurance policy is due immediately after you receive your first invoice from us.

_____ Most insurance companies **do not** reimburse for written materials or phone calls. Desert Wise **does not** submit claims for this service to the insurance company. The patient is responsible for full payment.

_____ Release and Assignment: I give Desert Wise, LLC and its staff my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for various health care operations.

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date

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Authorization for the Release of Patient Information Pursuant to 45 CFR § 164.508

- In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your written consent is required before disclosure of your personal health information.
- You have the right to inspect and receive a copy of your own protected health information to be used or disclosed, in accordance with the requirements of the Privacy Act and 45 CFR § 164.524.
- Any information shared pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA privacy rule.
- This request is valid for one year from the date of your signature, unless otherwise specified below or unless you otherwise revoke the request in writing. Written requests for revocation can be submitted at any time and must include your signature and the date.
- If you have any questions or concerns, please talk to your provider before completing this form. Completion and submission of this form means you do not have any remaining questions or concerns.

I. Patient information:

Patient Name			
Street Address			
City, State, Zip Code			
Telephone			
DOB		Last 4 of SSN	

II. Entity you are requesting records or information from:

Provider	Joye L. Henrie, PhD
Agency	Desert Wise, LLC
Street Address	1201 Eubank Blvd NE, Ste 1
City, State and Zip Code	Albuquerque, NM 87112
Telephone	505-361-1957

I authorize and request the disclosure of all protected information. I expressly request that the designated record custodian (i.e., listed in section II) disclose full and complete protected medical/mental health information, as indicated below:

- ☐ All mental health records, meaning every page in my record, including, but not limited to: office notes, history, consultation notes, inpatient/outpatient/emergency room treatment, clinical charts/records, assessment/testing reports, progress notes, status reports, treatment plans, all forms of correspondence, questionnaires/histories, and records received from other entities.
- ☐ Mental health progress notes for the following dates of service only: _____ to _____
- ☐ Billing statements for the following dates of service only: _____ to _____
- ☐ Other (specify): _ recommendations, functional limitations, and the impairment level of the resident to UNM and/or its departments ____

III. Protected and Sensitive Information

Certain information you are requesting cannot be released without specific authorization. Please initial below if you agree to release the following:

____ I recognize that the information disclosed may contain MENTAL HEALTH information, which is protected by federal and state law. I specifically consent to the disclosure of such information.

____ I recognize that the information disclosed may contain DRUG/ALCOHOL information, which is protected by federal and state law. I specifically consent to the disclosure of such information.

IV. Entity you are releasing records or information to:

Person or Provider	Joanna Fair, MD, PhD &/or other authorized agent
Agency (if applicable)	University of New Mexico
Street Address	
City, State and Zip Code	Albuquerque, NM
Telephone	505-272-6225

V. Period of Authorization

Authorization Start Date: _____ Authorization Expiration: ☐ Date _____ **OR** ☐ Action Completed

Signature: _____ Date: _____

Relationship to patient (if other than self): _____

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Fitness for Duty Questionnaire for UNM Residents

Please fill out form completely. If an item does not apply write "N/A." Do not write in the shaded areas.

1. General Information

Today's Date: (MM/DD/YYYY)		DOB: (MM/DD/YYYY)	Age:
Patient Name:		Gender:	Ethnicity:
Street Address:			Social Security Number:
City, State, Zip Code:			
Home/Cell Phone:	Can a voicemail from Dr. Henrie be left on this phone? ☐Yes ☐No	Work Phone:	Can a voicemail from Dr. Henrie be left on this phone? ☐Yes ☐No
Email:		Can Dr. Henrie email you? ☐Yes ☐No *(As noted in Desert Wise's Informed Consent, email is not considered a confidential form of communication.)*	
List any concerns you have about confidentiality/privacy/your patient rights:		Do you understand that Dr. Henrie will provide recommendations to your department regarding your ability to work? ☐Yes ☐No	
Did you receive a copy of Dr. Henrie's Privacy Policy? ☐Yes ☐No		Do you agree that Dr. Henrie has permission to provide recommendations to your department at UNM? ☐Yes ☐No	
Emergency Contact Name:	Relationship to You:	Emergency Contact Number(s):	

2. Primary Concern/Problem

Describe the primary concern/problem that caused your leave of absence from residency:	*Provider use only*:
When did this concern/problem start?	
What, if anything, caused or was associated with the start of this concern/problem?	
Has the concern/problem gotten worse, better, or stayed about the same over time?	
What solutions, if any, have been helpful in resolving this concern/problem?	
What solutions, if any, have not been helpful in resolving this concern/problem?	
What has changed that makes you feel you are able to return to work now?	
Who do you prefer to confide in?	

3. Psychological Functioning

In a single word, describe your mood over the past 2 weeks:			*Provider use only*:
Are you currently feeling helpless or hopeless? If so, please describe:	Yes ☐	No ☐	
Over the past week, have you had thoughts of killing yourself?	Yes ☐	No ☐	
Over the past week, have you had thoughts of killing someone else?	Yes ☐	No ☐	
Have you *ever* intentionally tried to kill yourself?	Yes ☐	No ☐	
Have you *ever* intentionally cut, burned, or otherwise harmed yourself?	Yes ☐	No ☐	
Has anyone close to you ever completed suicide?	Yes ☐	No ☐	
Do you currently own a firearm or plan to acquire one?	Yes ☐	No ☐	

4. Mental Health History

Have you *ever* received counseling or other mental health/substance abuse treatment? If yes, please describe:	Yes ☐	No ☐	*Provider use only*:
Have you *ever* been hospitalized for psychiatric reasons? If yes, please describe:	Yes ☐	No ☐	
Have you *ever* been prescribed medications to change your mood, thoughts, behaviors, or sleep (irrespective of who prescribed the medications)? If yes, please list names & timeframes of medications:	Yes ☐	No ☐	
Does anyone in your family have a history of substance abuse, depression, or any other mental health condition? If yes, please describe:	Yes ☐	No ☐	
Are you currently under the care of a psychiatrist? Name of your psychiatrist:	Yes ☐	No ☐	

5. Medical History

Do you have any serious and/or chronic medical diagnoses? If yes, please list:	Yes ☐	No ☐	*Provider use only*:
Have you *ever* had any surgeries? If yes, please list:	Yes ☐	No ☐	
Are you currently taking any prescription, over the counter, supplements, or herbal medicines? If yes, please list:	Yes ☐	No ☐	
Do you have any food or drug allergies? If yes, please list:	Yes ☐	No ☐	
Are you currently experiencing any chronic pain? If yes, where?	Yes ☐	No ☐	

Rate this pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)			

6. Personal and Social History

Where were you born?	Where were you raised?		*Provider use only*:
Who were you raised by?	Number of Siblings:	Birth Order Number:	
Are your parents divorced? ☐Yes ☐No If yes, how old were you?	Were you adopted? ☐Yes ☐No If so, at what age?	Were you ever placed in foster care? ☐Yes ☐No If so, at what age?	

In the last year, have you been physically hurt or abused?	Yes ☐	No ☐	
Have you *ever* been in an abusive relationship? If yes, when?	Yes ☐	No ☐	
Did you experience any abuse in childhood?	Yes ☐	No ☐	
Have you *ever* had legal problems? If yes, please describe:	Yes ☐	No ☐	
Have you *ever* had financial problems? If yes, please describe:	Yes ☐	No ☐	

7. Immediate Family

Are you married? ☐Yes ☐No	How many total times have you been married?	*Provider use only*:
Have you had a spouse precede you in death? ☐Yes ☐No If so, when?	If married, spouse's name and age:	
If not married, are you currently in a relationship? ☐Yes ☐No *(If no, skip to section about children.)*	Length of current marriage or relationship:	
How would you rate your overall satisfaction with your marriage/relationship? (Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)		
What challenges, if any, do you have in your relationship?		
What strengths do you have in your relationship?		

If you have children, please list them below:

Child's Name	Age	Special Needs, if any:	Gender		Living with You?		Is this your stepchild?	
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐

Is there anyone else currently living in your home? ☐Yes ☐No
If yes, please list:

8. Group Identities

Do you have any continued involvement in religious or spiritual activities? If yes, what is your affiliation?		Yes ☐	No ☐	*Provider use only*:
Do you have any religious practices or concerns that may alter your care? If yes, please describe:		Yes ☐	No ☐	
If you are no longer involved in religious or spiritual activities, but you have a past faith-based affiliation that is important to your care, please mark yes:	N/A ☐	Yes ☐	No ☐	
Do you have a cultural affiliation that is important to your identity? If yes, what is your affiliation?		Yes ☐	No ☐	
Are there any other affiliations or aspects of your identity that are important to your care? If yes, please list and/or describe:		Yes ☐	No ☐	

9. Education and Occupation

What is the highest level of education you have completed?			*Provider use only*:
If you have completed any college, please list your major(s)/degree(s):			
Did you have any learning or behavioral problems while in school? If yes, please describe:	Yes ☐	No ☐	
What residency/department are you in?			
How would you rate your overall satisfaction with your current job? (Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)			
What challenges, if any, do you have in your current job?			
What strengths do you have in your current job?			
What are your long-term career goals?			

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

NAME_____DATE_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "X" in appropriate column to indicate your answer)

	(0) NOT AT ALL	(1) SEVERAL DAYS	(2) MORE THAN HALF DAYS	(3) NEARLY EVERY DAY
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 figety 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	○	○	○	○
add columns	+	+	+	

GRAND TOTAL: _____

10. 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 VERY DIFFICULT AT ALL _____
SOMEWHAT DIFFICULT _____
VERY DIFFICULT _____
EXTREMELY DIFFICULT _____