MASTER

Welcome to

Sun Valley Behavioral Medical Center, Inc.

Please give us the following information, in order to help us expedite your services

Name _____ Date of Birth _____ Age _____

Sex: Male / Female SSN _____ Occupation _____

Marital Status: Single Married Divorced Separated Widowed Spouse Name _____

Mailing Address _____

City, State, Zip code _____ Phone Number (_____) _____

Email address _____

Emergency contact & phone # _____

If patient is a minor, Parent/Guardian Name _____

*Minor has to be accompanied by a person 18 years of age or older

*For Divorced Parents: Who has custody _____

Insurance Company Name _____

Policy Holder's Name _____ Policy Holder's DOB _____

Policy Holder's SSN _____ Relationship to patient _____

Office Policy

1. All information is kept in the strictest confidence. However, we do send acknowledgement to referring physicians, therapists, or agencies. We are also required by law to report incidents/suspicion of child/elderly abuse or threats to self and others.

2. Due to confidentiality, it is the patient's responsibility to directly schedule appointments, make appointment changes, request prescriptions, or phone inquiries.

3. The preferred form of contact is our office phone number. If your physician/therapist is not available you may leave a message with staff or on our confidential voicemail. If you wish your physician/therapist to return your call, please be sure to leave your name and phone number(s) along with a brief message concerning the nature of your call. Even if you consider your call to be urgent or highly important, please **do not attempt to contact your physician/therapist by other means than the official Sun Valley Behavioral phone number (i.e. personal phone, cell phones, and emails, as well as other form of electronic/web-based form of communication).**

4. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or contact local law enforcement. The local hotline can provide with support and brief intervention if needed, their services are available 24/7. The local hotline phone number is 760-352-SURE (7873).

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5. In an effort to reduce medical errors and improve patient safety, your picture will be taken as part of our identification process also called "positive patient identifier."

6. Sun Valley Behavioral Medical Center has agreements with various academic centers, so during your visit, you may be seeing different healthcare professionals (i.e., physician, nurse practitioner, nurse, psychotherapist, or counselor), who may be temporarily rotating through our clinic. These professionals may be at various levels of training (i.e., resident, intern, student), and will assist in your care. Their goal is to improve the quality of your care.

Patient Financial Responsibility Agreement

We at Sun Valley Behavioral Medical Center, Inc. (SVBMCI) are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles and Co-Payments: If you have not met your health plan's deductible on the date of service, we will collect and estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: It is your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: If your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Returned Checks: We charge a $35.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before you are to be seen in our office. Failure to cancel an appointment in a timely manner will result in a No Show fee of $50.00. Multiple No Shows (3 maximum) will result in the patient being discharged from our office.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

Contact: If you have any questions regarding your bill, please contact Mendez Billing Services at 760-355-8817.

I have read the above financial policies of SVBMCI as well as the office policy and agree to be bound by its terms. I also understand that SVBMCI has the right to amend these policies at any time.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____ Relationship to Patient: _____

Contact Phone Number of Responsible Party: _____

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NAME: _____ **Date of Birth:**_____ **Date:** _____

Complaint:
What has prompted your visit today? _____
Date of onset and past occurrence: _____
Triggering factors: _____
Alleviating factors: _____

Medical History:
Have you ever had any of the following illnesses?
____ High Blood Pressure/Hypertension
____ Diabetes
____ Hyperlipidemia
____ Thyroid
____ Chronic obstructive pulmonary disease
____ Asthma
Surgeries and dates: _____
Have you ever used any of the following? ____Cigarettes _____Alcohol _____Crystal _____Marijuana _____Cocaine
_____LSD _____Heroin _____Acid _____Downers _____Diet Pills

Medications:
Please list all current medications and doses:
_____
_____
_____
_____
_____

Have you ever had unwanted/allergic reactions to medications? _____If yes, what type of reaction? _____

History associated with mental health:
Have you ever been treated for depression or anxiety? _____
Have you ever had thoughts or acted to harm yourself or others? _____
How many hours do you sleep per night? _____ Do you feel rested when you wake up? _____
Do you have insomnia? _____
Are there any members of your family with mental health conditions? _____
(i.e. Bipolar, Schizophrenia, Suicide)

What is the highest level of education you have completed? _____
Are you currently employed? _____ For how long? _____
Have you ever been fired? _____
What was your longest job and for how many years? _____
Have you ever been in the military? _____ For how long? _____
How were you discharged? _____ Have you been in active combat? _____

Legal History:
Have you ever been arrested or imprisoned? _____

Living Arrangements/Family History:
With whom do you live?
_____
_____
_____
_____

Female patients:
When was your last menstrual period? _____
What type of contraception do you use? _____

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For use by adults – ages 18 and up (2WK/GLTE-Q)
Sun Valley Behavioral Med Ctr

Dear Sir or Madam:

The following are screening questions that will help us understand your treatment needs. There are no right or wrong answers.

	Please tell us about the frequency of any use of the following substances in the last two (2) weeks:	NOT AL ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)				
2	Nicotine products (electronic cigarettes)				
3	Alcoholic beverages (beer, wine, spirits, etc.)				
4	Marihuana (pot, weed, hash, gummies, etc.)				
5	CBD (oil, etc.)				
6	Cocaine (coke, crack, etc.)				
7	Amphetamine type stimulants (meth, speed, diet pills, ecstasy, etc.)				
8	Inhalants (nitrous oxide, glue, paint thinner, etc.)				
9	Sedatives or Sleeping pills (valium, xanax, ambien, etc.)				
10	Hallucinogen (LSD, acid, mushrooms, PCP, special K, etc.)				
11	Opioids (heroin, morphine, methadone, codeine, oxycontin, etc.)				

1. During a typical 7-day period (a week), how many times on the average do you do the following kinds of exercise for more than 15 minutes during your free time (write on each line the appropriate number).	Times per week
a) STRENUOUS EXERCISE (HEART BEATS RAPIDLY) (e.g., running, jogging, hocky, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous long-distance bicycling)	
b) MODERATE EXERCISE (NOT EXHAUSTING) (e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing)	
c) MILD EXERCISE (MINIMAL EFFORT) (e.g., yoga, archery, fishing from riverbank, bowling, horseshoes, golf, snow-mobiling, easy walking)	
2. During a typical 7-Day period (a week), in your leisure time, how often do you engage in any regular activity long enough to work up a sweat (heart beats rapidly)? [ ]OFTEN [ ]SOMETIMES [ ]NEVER/RARELY	

Age _____ Gender [ ]MALE [ ]FEMALE
[ ]employed full time [ ]employed part time [ ]unemployed

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Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "X" 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	0	1	2	3
Office use only: 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 difficult at all [ ]	Somewhat difficult [ ]	Very difficult [ ]	Extremely difficult [ ]

GAD-7				
Over the last 2 weeks, how often have you been bothered by the following problems? (use "X" to indicate your answer)	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
Office use only: Total _____ = _____ + _____ + _____				

FSG
This question is to get information about you level of sexual function in the last 2 weeks, whether you had sex or not.
Considering your level of desire, excitation (i.e. lubrication or erection) and orgasm; how would you rate your level of sexual function in general?

POOR		REGULAR			GOOD			EXCELLENT	
1	2	3	4	5	6	7	8	9	10

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PDQ-5					
The following questions describe problems people may have with their memory, attention or concentration. Please select the best response based on your experiences during the **past 7 days** (use "X" to indicate your answer)					
During the past 7 days, how often did you...	Never in the past 7 days	Rarely (once or twice)	Sometimes (3 to 5 times)	Often (about once a day)	Very often (more than once a day)
Have trouble getting things organized?	0	1	2	3	4
Have trouble concentrating on what you were reading?	0	1	2	3	4
Forget the date unless you looked it up?	0	1	2	3	4
Forget what you talked about after a telephone conversation?	0	1	2	3	4
Feel like your mind went totally blank?	0	1	2	3	4
Add up score in each column:					

SHEEHAN DISABILITY SCALE										
PLEASE MARK ONE CIRCLE FOR EACH SCALE										
WORK / SCHOOL The symptoms have disrupted your work / school work:										
Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10
SOCIAL LIFE The symptoms have disrupted your social life / leisure activities:										
Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10
FAMILY LIFE / HOME RESPONSIBILITIES The symptoms have disrupted your family life / home responsibilities:										
Not at all	Mildly			Moderately			Markedly			Extremely
0	1	2	3	4	5	6	7	8	9	10

DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

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1	Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	YES	NO
2	Did you have problems with depression before the age of 18?	YES	NO
3	Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	YES	NO
4	Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	YES	NO
5	Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	YES	NO
6	Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	YES	NO

www.sunvalleyb.com

CONSENT TO USE INFORMATION FOR RESEARCH PURPOSES

At Sun Valley Behavioral Medical Center, we conduct research projects in order to better understand psychiatric and behavioral disorders, and improve the care we provide. We do this by presenting our research results in scientific forums.

This is based on the use of clinical information registered in your chart. If we decide to extract any information from your chart, we assure that confidentiality of your identity will be preserved, based on HIPAA regulations.

You may refuse to give consent or withdraw your consent to use your information at any time; without jeopardizing or interfering with the treatment you receive.

- ☐ I give consent to use information for research purposes.
- ☐ I do not give consent to use information for research purposes.

Name_____ (if under age 18, a parent/tutor should sign)

Signature_____ Date_____

CONSENT TO BE PHOTOGRAPHED OR VIDEOTAPED FOR RESEARCH OR TEACHING PURPOSES

At Sun Valley Behavioral Medical Center, we conduct research projects in order to better understand psychiatric and behavioral disorders, and improve the care we provide. We do this by presenting our research results in scientific forums.

We request your consent in case we find it necessary and useful to videotape or photograph any clinical manifestation of your illness. We assure you that this material will be used in accordance to HIPAA regulations in order to protect your confidentiality.

You may refuse to give consent or withdraw your consent to be photographed or videotaped; without jeopardizing or interfering with the treatment you receive.

- ☐ I give consent to be photographed or videotaped.
- ☐ I do not give consent to be photographed or videotaped.

Name_____ (if under age 18, a parent/tutor should sign)

Signature_____ Date_____