# NEW DAY BEHAVIORAL HEALTH CENTER

Date Referral Received:________ Appt. Scheduled With:________ Date and Time of Appt:________

Staff Initials:________

**OUTPATIENT CLIENT REGISTRATION FORM**

CLIENTS LAST NAME________ FIRST NAME________ MI________

ADDRESS________

CITY________ STATE________ ZIP________ SEX________

HOME PHONE________ CELL PHONE________ DATE OF BIRTH________

CLIENTS SOCIAL SECURITY NUMBER________ MARITAL STATUS________

GUARANTOR INFORMATION (Name of person(s) responsible for payment)

SPOUSE'S NAME:________ DOB________ SSN________

MOTHER'S NAME:________ DOB________ SSN________

FATHER'S NAME:________ DOB________ SSN________

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PRIMARY INSURANCE:________ PHONE:________

SUBSCRIBER NAME:________ DOB:________ SSN:________

POLICY ID #:________ GROUP #________ EMPLOYER________

SECONDARY INSURANCE :________ PHONE:________

SUBSCRIBER NAME:________ DOB:________ SSN:________

POLICY ID #:________ GROUP #________ EMPLOYER________

OTHER INSURANCE :________ PHONE:________

SUBSCRIBER NAME:________ DOB:________ SSN:________

POLICY ID #:________ GROUP #________ EMPLOYER________

**IF MEDICAID/NC HEALTHCHOICE, LME-MCO**(circle one): **Sandhills / Alliance**

**IF TRICARE, SPONSOR'S RANK** ________ (Please see front desk if one of these is not your LME-MCO)

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**Please complete this section of the page only if client is a minor**

WHAT IS THE CHILD'S LIVING ARRANGEMENT________

WHO HAS LEGAL CUSTODY OF THE CHILD________

SCHOOL GRADE________ NAME OF SCHOOL________

BROTHER'S AND SISTER'S NAMES________

OTHER FAMILY MEMBERS IN NEW DAY BEHAVIORAL HEALTH SERVICES________

If client is in DSS custody please fill in information below:

COUNTY IN WHICH CHILD IS IN CUSTODY________ ADDRESS OF FACILITY________

CONTACT PERSON FOR CLIENT________ PHONE________

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**FOR OFFICE USE ONLY**

CLIENT NAME________ MEDICAL RECORD #________

THERAPIST PROVIDING SERVICES____________________ CHILD OR FAMILY PHYSICIAN____________________

ALLERGIES?____________________

CLIENT EMPLOYER(Or father's if client is a minor)____________________

OCCUPATION____________________ WORK PHONE____________________

SPOUSE'S EMPLOYER(Or mother's if client is a minor)____________________

OCCUPATION____________________ WORK PHONE____________________

NUMBER OF DEPENDENTS__________ NUMBER OF FAMILY MEMBERS LIVING IN THE HOME__________

MONTHLY INCOME (FAMILY)__________ LIST NAMES OF OTHER PERSONS LIVING IN THE HOME__________

**As a courtesy, we generally call to remind our clients of scheduled appointments. This may cause confidentiality concerns for you and because of this we would like to give you the opportunity to either request or decline this courtesy call. Please do so by initialing your preference: ____________PLEASE CALL ____________DO NOT CALL**

WHO REFERRED YOU TO US?____________________ MAY WE CONTACT TO EXPRESS OUR GRATITUDE?__________

IF YES, PHONE NUMBER AND ADDRESS____________________

PLEASE DESCRIBE IN DETAIL THE PROBLEM THAT IS BRINGIING YOU TO OUR FACILITY, INDICATE HOW LONG THE PROBLEM HAS BEEN GOING ON:____________________

____________________

____________________

WHAT ARE YOUR NEEDS FROM THE FACILITY AT THE PRESENT TIME:____________________

____________________

____________________

Providing information on race/ethnicity is voluntary and will be held confidential. This facility strives to provide services to all families in a culturally sensitive manner. In order to assist us in meeting the needs of our culturally diverse population, we ask that you complete the following section:

PLEASE SPECIFY THE CLIENTS CULTURAL/ETHNIC GROUP:

☐ White ☐ Black ☐ Hispanic

☐ Asian ☐ Other__________ ☐ Bi-racial (biological mother):____________________
(biological father):____________________

NAME OF PERSON WE MAY CONTACT IN CASE OF EMERGENCY:____________________ PHONE:____________________

ADDRESS (CITY, STATE, ZIP)____________________

**I AUTHORIZE THIS OFFICE TO RELEASE INFORMATION OBTAINED DURING EVLAUATIONS OR TREATMENT OF THIS CLIENT TO THE INSURANCE COMPANY INDICATED WHICH IS NECESSARY TO EXPEDITE AND SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE PAYMENT OF BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THIS PROVIDER. MEDICARE REGULATIONS MAY APPLY.**

____________________ ____________________

**CLIENT/LEGALLY RESPONSIBLE PERSON'S SIGNATURE** **DATE**

**FOR OFFICE USE ONLY**

CLIENT NAME____________________ MEDICAL RECORD #__________

## NEW DAY BEHAVIORIAL HEALTH CENTER, PC

## FEE AGREEMENT

Payment for services at New Day Behavioral Health Center is due when they are provided. As a courtesy to our clients and families, we will bill your insurance in accordance with information you provide to us. It is your responsibility to keep New Day Behavioral Health Center informed of any changes to your insurance coverage. You are obligated to pay any deductible or co-pay required under your insurance plan, at the time of service.

Charges are based on the type of service provided to you. If additional time or services (such as telephone sessions) are provided, a pro-rated fee will be charged. You remain legally responsible for all charges.

Below are a list of common services and fees that clients may encounter. Your provider will discuss these fees with you at the time of the request.

| | |
|---|---|
| Letters/reports for your insurance company or another agency | $150.00 per hour |
| Court related costs-letters, testifying, forensic reports etc.<br>(Costs for testifying include travel time from "door to door") | $175.00 per hour |
| Services that are not covered by your insurance company<br>(Certain types of testing, phone sessions, etc.) | $150.00 per hour |

You will be charged for all missed appointments. With sufficient notice, an appointment can generally be re-scheduled.

**FAILURE TO GIVE 24-HOUR NOTICE OF CANCELLATION WILL RESULT IN A $50.00 "NO-SHOW" CHARGE.**

**Note: Per CMS rules, Medicaid recipients will not be charged "no-show" fees but will be responsible for all other fees/charges. Medicaid recipients are responsible for informing New Day of changes in their insurance coverage or additional information needed to accurately bill Medicaid,-- e.g., start of/discontinuation of coverage, Medicaid as secondary insurance. If the recipient fails to provide New Day with such information, the recipient will be responsible for any monies owed for services rendered that are denied by Medicaid.**

This financial relationship will continue as long as we provide services or until such time as you notify us that you wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. When an account becomes 60 days past due, professional collection may be utilized and/or legal action taken.

**My signature below indicates that I have read and understand this fee policy. I agree to take responsibility for fees charged to my account.**

____________________________________ ____________________

**CLIENT/LEGALLY RESPONSIBLE PERSON'S SIGNATURE** **DATE**

**FOR OFFICE USE ONLY**

CLIENT NAME_________________________MEDICAL RECORD #____________

# NEW DAY BEHAVIORAL HEALTH CENTER

## *AUTHORIZATION TO PROVIDE SERVICE*

__________(initial) It is my choice and I authorize New Day to provide service to my child/myself/my family (circle one). I understand that participation is voluntary and I may discontinue service at any time. I understand that my insurance provider may be billed for the services received. I understand that New Day is required to notify the referring agency of my participation, withdrawal, or dismissal from services.

In the event of an emergency situation, I grant permission to seek emergency care/services from a hospital or physician.

I have full understanding of the items initialed above and have been provided with a copy of this form. A copy will be retained in my child's/my case record. I have been given the opportunity to ask questions and seek explanations for any items that I do not fully understand. I voluntarily agree to participate in the program/service as documented in my Plan of Care.

______________________________________________ ____________
Client Signature Date

______________________________________________ ____________
Legally Responsible Peron's Signature Date

______________________________________________ ____________
Witness Signature Date



Client Name: ____________________ Record #: ________________
Medicaid #: ________________

# NEW DAY BEHAVIORAL HEALTH CENTER

## INFORMED CONSENT FOR TREATMENT

**RIGHTS AND RESPONSIBILITIES**

- As a consumer of service, I am aware that I have certain rights and responsibilities as a participant in the service.
- I have the right to be treated with respect and dignity and to be free of abuse, neglect, exploitation and physical punishment.
- I have the right of informed consent – to have services explained in a manner I can understand. To be informed what is to happen, expectations, benefits, hazards, and alternatives to the service. Informed consent offers me a way to participate in service planning and provision.
- I have the right to have all information about myself and/or my family to be kept in confidence. Confidential information includes all forms, written, verbal, audio or videotapes, and electronic. Under law there are times when the right to confidentiality is no longer valid, these are:
  - Upon receipt of a court order to release information
  - In the event of a medical emergency
  - When there is suspicion of abuse and/or neglect
  - When there is a danger to self or others and/or threats of harm to self or others

  Note: If a Guardian Ad Litem has been assigned to advocate for the client, they will have access to your case record as part of their role and responsibilities. They will keep all records and information confidential as mandated in their job description.
- I have the right to choose a service provider agency or organization and to refuse service altogether. In the refusal of service, I take upon myself the consequences of such actions.
- I have the right to make complaints about the service of New Day. I am responsible to communicate my complaint in writing to my primary service provider or his/her supervisor.
- I am responsible to follow the rules of New Day Behavioral Health Center.
- I am responsible to be an active participant in the Plan of Care/Service Plan.

__________(initial) I am aware and understand my rights and responsibilities as provided to me by New Day providers.

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**INFORMED CONSENT**

_________(initial) I am aware of the services planned for myself/my child. I will participate in the development of a Service Plan and agree to its content. I am aware of the benefits and potential risks of the program/service. I have been provided the opportunity to discuss the Plan of Service and possible alternatives. I agree to participate in the program and understand my participation is voluntary. I agree to participate in programs/service.

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Client Name: ______________________

Record #: __________________

Medicaid #: __________________

# NEW DAY BEHAVIORAL HEALTH CENTER

## NOTICE OF GRIEVANCE PROCESS

It is the policy of New Day Behavioral Health Center (New Day) to provide a mechanism for clients/families/legally responsible persons (LRP) to communicate complaints or grievances with the intent of resolution and improved satisfaction with service delivery systems.

In the event that you have concerns about the service provided to you at New Day and would like to file a complaint, please follow the process listed below:

1. Clients/families/LRPs are encouraged to express displeasure, problems, complaints and/or grievances to their primary service provider first.
2. If the difficulty is with the service provider, communication of problems should be addressed to New Day's Owner.
3. It is recommended that problems be presented in writing. This written document should contain specifics of problem: for example, what happened, when, who was involved. State the nature of the problem clearly and expectations for resolution.
4. Upon receipt of the problem communication the primary service provider or owner will contact the client/family member/LRP within three working days. If phone contact is not possible, written communication should be sent to client/family member/LRP within three working days. Discussion should focus on specifics of problem and possible methods of resolution.
5. Efforts should seek to resolve the problem with the client/family member/LRP within 10 working days. New Day's owner will make every effort to assist the client/family member/LRP in gaining resolution of problem to the best of their ability.
6. If resolution is not possible by the owner, the owner will assist the client/family member/LRP in linking to services elsewhere.
7. If resolution is not possible or is unsatisfactory, the problem may be forwarded by the consumer to an impartial agency or consumer advocacy group(s), such as the Office of Disability Rights or the appropriate Managed Care Organization (MCO). Phone numbers for the Office of Disability Rights and the MCO will be provided to clients at the beginning of service.
8. Appeals related to service reduction, denial, or discharge from service shall be communicated to the specific provider or the New Day owner. Appeals processing will follow Medicaid guidelines, where applicable.

**NC Division of MH/DD/SAS**
Office of Advocacy and Customer Service
1-919-715-3197 OR 1-800-662-7030
**Disability Rights, NC**
1-919-856-2195 OR 1-877-235-4210
**NC LCSW Board** 1-800-550-7009
**NC LCAS Board** 1-919-832-5975
**NC LMFT Board** 1-919-654-6914

**Alliance Behavioral Health**
1-877-235-4210
**DHHS**-919-855-4800
**NC LPC Board**
1-844-622-3572
**NC Psychology Board**
1-828-262-2258
**NC Medical Board**
1-800-253-9653 OR 1-919-326-1100 OR 1-919-326-1109

How to file a complaint related to my services, if necessary, has been explained to me and I have been given a copy of this process.

______________________________ ______________________________
Client name Witness Date

______________________________ ______________
Client/Legally Responsible Person's Signature Date

Revised 1-19-2017

# NEW DAY BEHAVIORAL HEALTH CENTER

## NOTICE OF CLIENT RIGHTS

New Day Behavioral Health is committed to supporting and protecting the basic rights of each client and their family members that are provided services. These Rights include but are not limited to:

A. The right to the least restrictive, most appropriate, and effective positive treatment available.
B. The right to reasonable enjoyment of privacy, in a clean and safe surrounding.
C. The right to enjoy freedom of thought, conscience and religion, and the right to receive service in a manner that is non-coercive and that protects the right of self-determination.
D. The right to have his/her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his/her life, the right to participate in the development of the plan of services to be offered by New Day and to be informed of expectations of all parties involved in the implementation of the plan.
E. The right to receive appropriate and reasonable guidance, support, and supervision, and to be taught to fulfill appropriate responsibilities.
F. The right to treatment regardless of age or degree of illness or disability.
G. The right to be protected from all forms of sexual exploitation, sexual advances, sexual harassment, or sexual offenses of any nature.
H. The right to access his/her case files for the purpose of review, correction or addition as specified in the policy on client records.
I. The right to receive care in a manner that recognizes variations in cultural values and traditions.
J. The right to be free from coercion with regard to religious decisions.
K. The right to not be identified in connection with publicity for the agency which shall bring the client or the client's family embarrassment, and the right to have his/her identity protected in the context of any agency reports, statistical analyses or case summaries published.
L. The right to not participate in public performances against the wishes of the person served or without the informed consent of that person and, in the case of a minor, of both the person served and the legally responsible person.
M. The right to not be forced to acknowledge in public, dependency on or gratitude to New Day.
N. The right to fully understand his/her treatment plans, to have the treatment plan thoroughly explained to him/her, the right to have the treatment plan written in a language that the client can understand and the right to receive a copy of the treatment plan. If a copy of the plan is desired, communication with the treating provider is recommended. The treating provider along with New Day records staff will assist the client in obtaining a copy of the treatment plan. When communication barriers exist, New Day will contract with professionals as needed to facilitate communication.
O. The right to access an attorney or guardian ad litem and meet with them privately and the right to contact and consult with other legal or medical providers at his/her own cost.
P. The right to confidentiality of all client records with release or obtainment of any confidential information, except as permitted by law and interpreted by agency counsel, to be limited by written prior consent from the client and/or legally responsible person (LRP).
Q. The right to information that allows an informed choice about the use of services, including the range of services available at New Day, and the benefits and risks of proposed services.
R. The right to refuse any service, medication or treatment without threat of termination, unless such rights have been limited by law or by court order, and to be informed of the potential consequences of such refusal (i.e. continuation of symptoms, deterioration, or a change in the agency's ability to provide services.)
S. The right to be informed in writing prior to service delivery or at the time of service of any fees for service, the agency's expectations with regard to outcomes, the client's responsibilities, hours during which services are available, any rules established to govern client conduct, and reference to any activities which could result in discontinuation of services.

T. The right to request and receive a complete copy of New Day's Client Rights Policy (acknowledgement of receipt will be kept in the client record.) (Special accommodations shall be made as necessary to ensure that non English speaking clients, the visually impaired, and the hearing impaired are fully informed of their rights and responsibilities.)
U. The right to file a complaint according to the New Day Grievance Policy and Procedure if the client or the client's LRP feels any of their rights have been violated, or to express dissatisfaction with services provided.
V. The right to access all civil rights.
W. The right to contact the Disability Rights, NC for Persons with Disabilities.

**Special Protections:**

A. New Day prohibits requiring a client's direct involvement in funds solicitation for the facility.
B. New Day prohibits a client's participation in any activity involving audio or visual recording and research without the voluntary signed, time limited consent of the client and/or the client's LRP.
C. Any client of New Day will not participate in or be subject of any research project without their informed, written consent.
D. New Day's staff members and contracted providers are required to immediately report any alleged violations of a client's rights to the Owner. Any staff member or contracted provider who reports such an incident in good faith shall not have their status jeopardized in any way.
E. Employees/contracted providers will protect clients from harm, abuse, neglect, and exploitation.
F. Employees/contracted providers will not subject a client to any sort of abuse or neglect.
G. Staff/contracted providers will not sell to or purchase personal property from or to clients.
H. New Day does not use restrictive interventions.
I. Any violation of paragraphs F through H of this article is grounds for employee dismissal or contract termination for Unsatisfactory Performance.

I have received a copy of the Client Rights as required by the North Carolina Confidentiality Rules for Mental Health, Developmental Disabilities and Substance Abuse Services (APSM 45-1).

____________________________ ____________________________

Client Name Witness Date

____________________________ ____________

Client/Legally Responsible Person's Signature Date

# NEW DAY BEHAVIORAL HEALTH CENTER

## NOTICE TO CLIENT REGARDING COORDINATION OF CARE

New Day Behavioral Health acknowledges the importance of maintaining relationships between outpatient behavioral health service providers, primary care providers and/or other professionals involved in our client's care. These relationships allow for clients and their providers/professionals to work collaboratively in making healthcare decisions. In an effort to facilitate this process, New Day Behavioral Health will adhere to the following procedures:

A. New Day will ensure that each client, where appropriate, has a referral for outpatient treatment from the PCM and/or professional responsible for client's care.
B. New Day will inform clients of this policy at the time of request/registration for services by including a statement to this effect in the client registration packet, and will obtain client's/legally responsible person's signature at the time of admission for services.
C. New Day will obtain a signed release of information form from the client or legally responsible person prior to releasing information to the referring provider, PCM, or other involved professional(s).
D. New Day will provide initial feedback to the referring provider and/or other involved professional(s) following the client's initial assessment and evaluation in the form of a summary letter and/or copy of the client's treatment plan.
E. New Day will provide updates to referring providers/PCM's and/or other involved professionals regarding client's progress, as deemed necessary, to facilitate client's successful progress in treatment.

I have reviewed and/or received a copy of the New Day Behavioral Health Coordination of Care Policy and Procedure. I also understand that it is my responsibility to inform New Day of any changes in my/my child's PCM or any other professional involved in my/my child's care.

______________________________ ______________________________
Client Name/MRN Witness Date

______________________________ ______________
Client/ Legally Responsible Persons Signature Date

# NEW DAY BEHAVIORAL HEALTH CENTER

## NOTICE OF PRIVACY PRACTICES

This Notice describes how we may use and disclose medical information about you and how you may gain access to this information.

### WE ARE REQUIRED BY LAW TO PROTECT YOUR HEALTH INFORMATION

Much of the information we collect about you is referred to as "protected health information" (PHI). This information has the potential to identify you as an individual. We maintain this information about you in your medical record. Some PHI may also be maintained in electronic records. We are required to follow the guidelines established in this Notice of Privacy Practices. We reserve the right to change the terms of this Notice at any time. You have the right to request a copy of changes made to this Notice. Any changes made to this Notice will be available for your review in our office.

### WE MAY USE AND DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

New Day Behavioral Health Center may use and disclose your PHI without your consent for the following reasons:

- **For Treatment-**We may use or disclose information with health care providers who are involved in your health care. We may also disclose PHI to another physician if that physician referred you to us for services. This may also include clinical notes as requested by your insurance company or referring provider.
- **For Payment-** We may share your PHI with agencies for the purpose of billing and for services provided to you. This information may include data that identifies you, such as your SSN, DOB and name.
- **For Health Care Operations-**We may use or disclose information to manage our programs and activities such as assessing the quality of services that you receive.
- **Appointments and Other Health Information-**We may send you reminders for care or appointments scheduled. We may also send you information about other services that may be of interest to you.
- **For Public Health Activities-**We may use or disclose PHI as required by law to report certain communicable diseases to health agencies. For example, we are required to report any cases of HIV, certain STDs and tuberculosis to the Health Department.
- **As Required by Law and for Law Enforcement-**We may disclose your PHI: in response to a court order; to avoid harm or avert a serious threat to a person or the public; when reporting abuse, neglect or exploitations.
- **For Health Oversight-**We may use or disclose your PHI when necessary to inspect or investigate health care providers.
- **For Government Programs-**We may use and disclose information for public benefits under other government programs, such as the determination of Supplemental Security income (SSI) benefits.
- **Disclosures to Family, Friends and Others-**We may disclose information to your family or to other persons who are involved in your care. You have the right to object to the sharing of information with any persons within this classification. We will make every attempt to honor any reasonable wishes in regard to restricting the PHI information shared; however, we retain the right to deny your request if it interferes with our ability to conduct treatment, payment or other health care operations.
- **In Emergency Situations-**We may use or disclose information as necessary to meet the demands of emergency situations, such as medical, psychiatric, or behavioral conditions that require immediate attention.

# NEW DAY BEHAVIORAL HEALTH CENTER

It is important for you to remember that we will use and disclose only the minimum amount of PHI necessary to comply with the above requirements.

**Any other use or disclosure of your PHI requires your written authorization**

- **You have the right to review and receive copies of your records-**If it is determined by a clinical professional that the information you requested could prove detrimental or harmful to you or someone else, we will deny access to only that specific information. We may choose to have specific information summarized and present you with that summary information. We cannot provide copies of any information sent to us by another source.
- **You have the right to request, to correct or update your records-**You have the right to request an amendment to your PHI in writing along with an expiration date for such an amendment.
- **You have a right to request a list of disclosures-** You have a right to request a list of disclosures of your PHI. You must make this request in writing.
- **You have a right to request limits on uses or disclosures of PHI-** You have a right to request that we restrict how your information is used or disclosed. We are not required to honor this request. Such a request must be made in writing.
- **You have a right to revoke your authorization for us to share or disclose information about you-**You must make this request in writing
- **You have a right to choose how we communicate with you-**You have a right to request how we contact or communicate with you. This request must be made in writing.
- **You have a right to file a complaint-**You have a right to file a complaint if you do not agree with how New Day Behavioral Health Center has used or disclosed your information.
- **You have a right to request a copy of this Notice-**You have a right to request a paper copy of this Notice at any time. Such a request must be made in writing.

**How to File a Complaint or Report a Problem**

If you believe we have violated your privacy rights or want to report a problem or complaint about how we have used or disclosed your information about you, you may do so by contacting the following:

Dr. Sonia M. Rhodie
New Day Behavioral Health Center, PC
1830 Owen Drive. Ste 203
Fayetteville, NC 28304
910-483-6427 x103

______________________________ ______________________________

**Client Name** **Witness (Office staff)** **Date**

______________________________ ____________

**Legally Responsible Persons Signature** **Date**

Revised 10/10/17

# NEW DAY BEHAVIORAL HEALTH CENTER

## NOTICE TO CLIENT REGARDING AFTER HOURS ACCESS TO CARE

New Day Behavioral Health acknowledges the importance of continuity of care and access to providers during times of crisis and/or emergency. In an effort to provide our clients with access to providers outside of our normal hours of operation, clients are encouraged to adhere to the following procedure:

A. Contact New Day at (910)483-6427.
B. Once you have reached the answering service, please provide the following information:
   a. Caller's Name
   b. Client's Name and Address
   c. Date of Birth
   d. Name of Provider
   e. Last appointment with provider.
   f. Reason for your call.
   g. Number where you may be reached for a return call.
C. Once your information has been received, the answering service will contact the on call provider and share the information you have provided. The on call provider will then contact you to discuss your concerns.

I have reviewed and/or received a copy of the New Day Behavioral Health Center After Hours Access To Care Policy and Procedure.

________________________________________
Client Name

________________________________________ ________________________________
Client/LRP Signature Date Witness Date

# NEW DAY BEHAVIORAL HEALTH CENTER

## NOTICE TO CLIENT REGARDING MISSED APPOINTMENTS

New Day Behavioral Health acknowledges the importance of consistent participation in therapy to obtain maximum benefits. Therefore, it is important that clients maintain consistent appointments and participation in therapy as outlined in their treatment plans and/or discussed with their provider. A consistent pattern of missed appointments is considered noncompliance with treatment recommendations and may result in reduced overall improvement and/or alleviation of symptoms. In an effort to maximize our client's benefit from services, New Day will adhere to the following policy regarding missed appointments:

A. If a client does not keep their initial/first appointment, the provider has the option of not allowing the client to reschedule the appointment.
B. Clients who "no show" for their follow-up appointments may receive a letter from their provider, or a telephone call from the office regarding the missed appointment. Clients will be encouraged to contact the office to reschedule the missed appointment to maintain consistency in care.
C. Clients who demonstrate a pattern of missed appointments in the form of 3 or more late cancellations (same day cancellation) or "no shows", will be viewed as noncompliant with treatment recommendations and may be subject to termination of services by New Day providers.
D. If a New Day provider makes the decision to terminate services based on treatment noncompliance due to missed appointments, the provider will inform the client in writing of this decision, and provide a list of other agencies in the area that may be able to provide services.
E. The client has the right to appeal the decision to terminate services with their assigned provider; however, the provider maintains the final decision regarding resumption or termination of services.

I have reviewed and/or received a copy of the New Day Behavioral Health Center Missed Appointments Policy and Procedure.

________________________________
Client Name

________________________________ ________________________________
Client/LRP Signature Date Witness Date

# NEW DAY BEHAVIORAL HEALTH CENTER

Client Name:______________________ Record #: ______________

## Adult History Form

To be completed by patient

All information on this form will be confidential

Today's Date___________

*If you need help filling out this form, please ask for help.*

The following information will be helpful in our work together.

Name:______________________ Age:________ Date of Birth:__________

Ethnic Background:______________ Medical Record #: (Completed by Staff)__________

**Personal History**

**Family**

Circle present marital status: Single Married Divorced Separated Widowed

Number of marriages? ______

Number of pregnancies?______

Do you have any children? Yes No If "Yes", please list:

| Name | Age | Blood/Step/Adopted | Living with you? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

**Work/School**

What kind of work do you do?______________________________

How long have you done this type of work?______________________

How many employers/jobs have you had in the last five years?______________

Have you ever had any problems in the workplace? ______________________

__________________________________________

Have you served in the military? Yes No If "Yes", branch ______________

What kind of work does our spouse/partner do?__________________

Do you have any financial problems? ______________________

Highest grade or degree you completed in school: ____________________

Do you now or have you ever had any problems in school (for example, learning or behavior problems)?

____________________

____________________

**Other**

Have you ever been arrested? Yes No For: ____________________

Date: __________ Result: ____________________

Has spirituality been important in your life? Yes No

Are you active in a church, synagogue, mosque, or community organization? Yes No

What are some of your hobbies/interests? ____________________

**Medical History**

Who is your family/primary care doctor? ____________________

During the last 6 months, have you had any problems performing daily activities as a result of physical/medical problems? No Yes (explain): ____________________

____________________

____________________

Are you presently experiencing physical pain? Yes No If yes, on a scale of 1 (least) to 10 (most) how severe is your pain? _____ Where is your pain? ____________________

What does the pain feel like (i.e., sting, ache, radiate, etc.) ____________________

Do you have any health problems which need to be addressed by your primary care physician? No Yes (explain): ____________________

Please list all medications that you currently take:

| Medication Name | Dose/Times per Day | Who Prescribed? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Do you have any medication allergies? Yes No If "Yes" , please list: ______________________

______________________________________________________________________

What is the reaction?__________________________________________________

Are you allergic to Latex? Yes No

Other allergies? Yes No If "Yes", please list:______________________________

_______________ Reaction:______________________________________________

Have you ever had surgery? Yes No If "Yes", please list: ______________________

______________________________________________________________________

**Family History**

Is your father living? Yes No Is your mother living? Yes No

Please list the ages and sex of any brothers and sisters and indicate if any are deceased:

| Name | Age | Sex | Living/Deceased |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have any of your blood relatives ever had any of the following? Please list beside each who has/had the illness.

Please check all that apply:

| | | |
|---|---|---|
| Diabetes | Depression | Bipolar Disease |
| Heart Disease | Alcohol or Other Drug | Schizophrenia |
| Stroke | Problems | High Blood Pressure |
| Lung Disease | Violent Behavior | Liver Disease |
| Cancer | Nerves | Other Emotional Problems |

Have you ever seen a psychiatrist, psychologist, or counselor before? Yes No If "Yes", please list:

| Name | Date from –to | Problem | Did it help? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list any medications you have taken in the past to treat mental health problems:

_______________________________________________

_______________________________________________

_______________________________________________

Have you ever been hospitalized because of mental health problems? Yes No If "Yes", please list:

| Name | Date from—to | Problem | Did it help? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever attempted suicide? Yes No If "Yes", how and when:______________________

_______________________________________________

Has anyone close to you attempted or committed suicide? Yes No

If "Yes", who? ________________________________________

Do you have any current thoughts about hurting yourself or committing suicide? Yes No

Do you have a history of being mentally, physically, or sexually abused? Yes No

Do you have any current thought about hurting or killing someone else? Yes No

Do you have a history of hurting others mentally, physically, or sexually? Yes No

Please describe any current or past drug usage:

| Drug | Currently use Y/N | How Much/How often | Last Used |
|---|---|---|---|
| Tobacco | | | |
| Alcohol | | | |
| Marijuana | | | |
| Cocaine | | | |
| Heroin | | | |
| LSD | | | |
| Amphetamines | | | |
| Barbiturates | | | |
| Prescription Pain Medication | | | |
| Other: | | | |

Have you ever felt that you need to cut down on your drinking or drug use? Yes No

Have you or others ever been annoyed by your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever had a drink or used drugs first thing in the morning to steady Your nerves or get rid of a hangover of just to get the day started? Yes No

Have you ever been in treatment for drug or alcohol problems Yes No

If "Yes", please list:

| Program | When | Problem | Did it help? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

*Please circle any of the following problems you have experienced in the past six months:*

| | | | |
|---|---|---|---|
| Nightmares | Sleeping too much | Self-care or grooming problems | Irritability |
| Sleeping too little | Crying spells | Mood swings | Anxiety attacks |
| Eating problems | Worrying | Unusual fears | Constipation |
| Difficulty urinating | Cant Concentrate | Dizziness | Tremors |
| Headaches | Nausea | Vomiting | Fainting |
| Memory problems | Chest Pains | Breathing Problems | Seizures |
| Unusual Thoughts | Heart Palpations | Weight change | Diarrhea |
| Blackouts | Lack of energy | See things that are not there | Night Sweats |
| Hearing Voices | Sexual problems | Racing thoughts | |

Are there any additional problems or major life events that would be important to your care?

________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________

Client Signature ______________________ Date ______________

Acknowledgment of review:

Clinician Signature ______________________ Date ______________