OASIS Behavioral Health Services — New Patient Registration

Patient Information:							
Name:							
Date of Birth:			SSN:				
Address:		City:		State:		Zip:	
Home Phone:		Cell Phone:		Work Phone:			
Is it ok to send mail to your address? **Yes** ☐ **No** ☐		Which phone number do you prefer we use? **Home** ☐ **Cell** ☐ **Work** ☐					
Emergency contact:		Relation:		Phone Number:			
How did you find out about us?	Friend	☐	Family member	☐	Website	☐	
	Facebook/Instagram	☐	Doctor: _____	☐	Other: _____	☐	

Financially Responsible Party (if same as above, put "self"):			
Name:			
Address:	City:	State:	Zip:
Date of Birth:	SSN:		
Relationship to Patient:			
Home Phone:	Cell Phone:	Work Phone:	
Employer:	Employer's Phone:		

Primary Insurance	**Secondary Insurance**
Insurance Name:	Insurance Name:
Member/Policy I.D. #:	Member/Policy I.D. #:
Group #:	Group #:
Employer:	Employer:
Policy Holder Name:	Policy Holder Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
SSN:	SSN:
Address:	Address:

Assignment of Benefits: I hereby authorize and request my insurance to pay directly to Oasis Behavioral Health Services the amount due for services rendered to me or my dependent.

Release of Information: I authorize the release of any medical information necessary to process this claim. This may include, but not be limited to, an outpatient treatment summary describing prognosis, frequency of treatment, and/or medications prescribed. This is a continuing consent for release of psychotherapy and/or substance abuse records for the duration of my treatment or until rescinded in writing.

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Oasis Behavioral Health Services. I understand Oasis Behavioral Health Services may take legal action to obtain payment if my account is in arrears and I have not made prior arrangements for payment. I will be responsible for any fees involved in the collection of this debt if sent to an outside collection agency or attorney. These fees will be added to my total amount due.

Patient Signature:	Date:
Parent/Guardian Signature:	Date:
Witness Signature:	Date:

OASIS
Behavioral Health Services

Notice of Privacy Practices

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the notice you will find how health information about you (as a patient of this practice) may be used and disclosed as well as how you can receive access to your health information.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the confidentiality of your health information as required by law. We are aware that some of these laws may seem complicated, so feel free to ask any of our staff if you require clarification.

Uses and Disclosures with Neither Consent nor Authorization

State law, HIPAA regulations, and our code of ethics specifically guarantee your privacy as our patient. However, there are some situations in which confidentiality cannot be guaranteed. The following are circumstances that may require us to use/disclose your health information **without** a signed release:

- Child and Elder Abuse: We must report any abuse, neglect, or exploitation to the proper authorities.
- Serious Threat to Health or Safety: We must notify the appropriate persons if we believe a patient is an imminent danger to themselves or others.
- Judicial or Administrative Proceedings: Your information may become subject to disclosure if any of the following apply: you become involved in a lawsuit, we receive a subpoena or court order, if you are an inmate or under custody of a law enforcement officer, or if requested by federal officials for intelligence and national security.
- Member/ Veteran of U.S. or Foreign Military Forces: If required by the appropriate authorities.
- Workers Compensation, Insurance, or Managed Care Program: Your contract with any of these programs may permit administrative access to your records.

Client's Rights and Clinician's Duties

- Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or location (e.g. sending your bill to a alternate address because you prefer a family member not know you come here).
- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction that you request.
- Right to Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your clinician. Under certain circumstances your request may be denied by your clinician, who will discuss their decision with you.
- Right to Amend: To request an amendment, you must submit your request in writing to your clinician as well as provide them with information that supports your request.
- Paper Copy: You have the right to obtain a paper copy of this notice from our office upon request at any time.
- Authorization for Other Uses and Disclosures: We will obtain your written authorization for any uses and disclosures that are not identified by this notice or permitted by applicable law.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Shawn R. Cade, P.O. Box 219 Barboursville, WV 25504. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

BY SIGNING THIS FORM YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____	_____
Patient Signature	Parent/Guardian Signature
_____	_____
Witness Signature	Date

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Witness Signature	Date

OASIS
Behavioral Health Services

Informed Consent for Telehealth Services

If my treatment provider has recommended telehealth services, I understand and recognize the risks, benefits, and alternatives to the use of the telehealth platform. I understand the following:

- I understand I have the option to withhold consent at this time or to withdraw this consent at any time, including anytime during a session, without affecting the right to future care, treatment, or risking the loss or withdraw of any program benefits to which I would otherwise be entitled.

- I understand the benefit of utilizing the telehealth platform, for I will be able to participate in telehealth services in a safe secure manner while limiting the barriers of transportation and local access to care.

- I understand the potential risks to utilizing the telehealth platform, for there could be partial or complete failure of the equipment being used which may result in the provider's inability to complete the evaluation or treatment services.

- I understand there are no permanent video recordings of my sessions unless I give written consent to be recorded for training or therapeutic purposes.

- I understand that I have HIPAA protections equal to the protections that exist as an in-person service recipient.

- Dissemination of client identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my consent.

- I understand there are circumstances under which online behavioral health services are not the appropriate or most effective treatment. I agree that my provider and I may determine that certain services are inappropriate under this medium.

- If I am having medical, psychiatric, or other critical issues which require face-to-face intervention, it is my responsibility to seek that level of help. **IF I AM CURRENTLY CONSIDERING OR THREATENING SUICIDE OR ANY FORM OF HARM TO MYSELF OR OTHERS, I TAKE FULL RESPONSIBILITY FOR SEEKING APPROPRIATE HELP IMMEDIATELY BY CONTACTING 911 OR GOING TO MY LOCAL EMERGENCY CENTER.**

- I understand I can request a printed copy of the *Terms of Use and Notice of Privacy Policies* regarding this treatment platform.

- [For services provided to home computers only] I take full responsibility for the security of treatment-related correspondence and records on any computer that I may use for these purposes. Correspondence or other information sent to me by my provider may be held liable for any breach of confidentiality regarding electronic or paper records which occur as a result of my failure to secure the computer through which I am receiving services.

Having read and understood, I consent to telehealth services. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered.

Patient Signature	Parent/Guardian Signature
Witness Signature	Date

For Office Use Only:
Date reviewed: _____
Clinician's Initials: _____

Adult Psychosocial History

(18 and up)

Please complete **all** questions to the best of your ability and as honestly as you can. If there is a question that does not pertain to you, just write N/A (not applicable) in the space provided. Your therapist will review this questionnaire with you to assure accuracy and to elaborate where indicated.

If you are uncomfortable with answering any of the following questions, simply leave it blank and speak to your therapist about it.

All information that you share with this office is **CONFIDENTIAL** and will not be shared with anyone outside of this office without your written permission or a court order.

Name:			
DOB:		SSN:	
Marital Status:		Gender:	
Address:			
City:	State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	
Occupation:	Employer:	Employer's Phone:	
Family Physician:		Physician's Phone:	
Date of Last Physical Exam:		Performed by:	
Results of Exam:			

Problem Description: Describe why you decided to schedule an appointment, how long you've been experiencing this issue(s), and what caused you to seek help at this time.

Treatment Goals: What goals do you want to achieve through your treatment?
1.
2.
3.

I am seeking help for: (Please check all that apply)			
Emotional/psychological problems	☐	Family issues	☐
Couples issues	☐	School problems	☐
Job stress	☐	Alcohol and/ or drug issues	☐
Sexual problems	☐	Legal problems	☐
Financial issues	☐	Health issues	☐
Death of a loved one(s)/ grief	☐	Behavioral problem in another person	☐
Chemical use in another person	☐	Other: _____	☐

Current Symptom Checklist (Rate intensity of symptoms <u>currently</u> present)

None: this symptom is not present ● **Mild:** Impacts quality of life, but no significant impairment on day-to-day functioning
Moderate: Significant impact on quality of life and/or day-to-day functioning ● **Severe:** Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed mood	☐	☐	☐	☐	Laxative/diuretic abuse	☐	☐	☐	☐
Suicidal thoughts	☐	☐	☐	☐	Sleep disturbance	☐	☐	☐	☐
Homicidal thoughts	☐	☐	☐	☐	Poor impulse control	☐	☐	☐	☐
Sudden weight change	☐	☐	☐	☐	Rapid heartbeat	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	Loss of sexual desire	☐	☐	☐	☐
Excessive exercising	☐	☐	☐	☐	Nervousness	☐	☐	☐	☐
Upset stomach	☐	☐	☐	☐	Pain	☐	☐	☐	☐
Chest pain/tightness	☐	☐	☐	☐	Excessive worry	☐	☐	☐	☐
Confusion/difficulty concentrating	☐	☐	☐	☐	Seeing things other's don't	☐	☐	☐	☐
Indecisiveness	☐	☐	☐	☐	Panicky	☐	☐	☐	☐
Fear of people, places, things	☐	☐	☐	☐	Excessive pill use	☐	☐	☐	☐
Numbness	☐	☐	☐	☐	Using pain killers	☐	☐	☐	☐
Temper outbursts	☐	☐	☐	☐	Alcohol problems	☐	☐	☐	☐
Racing thoughts	☐	☐	☐	☐	Binging/purging food	☐	☐	☐	☐
Hearing voices others don't	☐	☐	☐	☐	Constipation/diarrhea	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	Memory problems	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐	Feelings of dread	☐	☐	☐	☐
Grief	☐	☐	☐	☐	Shortness of breath	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	Lump in throat	☐	☐	☐	☐
Self mutilation	☐	☐	☐	☐	Shyness	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	Excessive sweating	☐	☐	☐	☐
Excessive fears	☐	☐	☐	☐	Nausea	☐	☐	☐	☐
Apathy	☐	☐	☐	☐	Faintness or dizziness	☐	☐	☐	☐
Crying spells	☐	☐	☐	☐	Significant appetite change	☐	☐	☐	☐

Behavioral Dysfunction/Abuse History (Please check any of the following which are [or have been] a problem):			
Compulsive gambling	☐	Religious abuse/addiction	☐
Compulsive sexual acts	☐	Compulsive spending	☐
Eating disorder	☐	Compulsive overeating	☐
Dependent relationship(s)	☐	Explosive temper	☐
Obsessive/compulsive	☐	Tobacco addition	☐
Sexual offender	☐	Caffeine addiction	☐
Physically abused	☐	Victim of sexual abuse	☐
Child of alcoholic	☐	Neglected as a child	☐
Unsatisfactory relationships	☐	Self-mutilating behavior	☐
Substance misuse	☐	Alcohol misuse	☐

Have you been treated previously for mental health (including therapy and/or medication management)? If so, when and where?
Have you been treated in the last year? **Yes** ☐ **No** ☐ **If yes, approximately how many visits:** _____

Please list any adult illnesses – including present illness, head injuries, and/or seizures:

List any medications you are currently taking, including dosage. (Continue on back of packet if needed)

Medication: (ex. Lexapro)	**Dosage** (ex. 10 mg)	**Frequency** (ex. 2x daily)	**Prescribed By** (ex. Dr. Ross)

List any SEVERE ALLERGIES to foods, medications, or inhalants:

Family History

Please list your birth/immediate family (e.g. Parents, siblings, spouse, children):

Name:	Relationship to you:	Age:

List any family members that have had a history of mental illness or substance use disorders (Please use last page if necessary:

Relative	Illness/substance

Relationship History

Sexual Orientation

Heterosexual	☐	Homosexual	☐	Bisexual	☐	Celibate	☐
Other (Please specify): _____							

Relationship status: (please check your current status)

Married	☐	Single	☐	Divorced (# of times____)	☐	Never married	☐
Engaged	☐	Widowed	☐	Separated	☐	Living together	☐

If in relationship:			
Partner's name:_____		Age:_____	Occupation:_____
If married: Date of marriage:_____		Status of marriage: ☐ Satisfactory	☐ Unsatisfactory

Divorce History:

	Date Married	Date Divorced	Reason for Divorce
1.			
2.			

	Yes	**No**
1. Have you had affairs?	☐	☐
2. Has your partner had affairs?	☐	☐
3. Do you want professional help with anything related to marriage and/or relationship with your partner?	☐	☐

Have you had any issues in the following areas? (Please check all that apply)

Females Only		**Males Only**		**Bot sexes**			
Vaginal spasms	☐	Not able to have erection	☐	Painful intercourse	☐	Low/lack of sexual desire	☐
Delay or absence of orgasm	☐	Not able to keep erection	☐	Avoidance of sexual curiosity	☐	Severe emotional discomfort about sex	☐
Premature climax	☐	Premature ejaculation	☐	Repeated sexual conquest	☐	Numerous affairs	☐
Inability to lubricate during sexual arousal	☐	Inability to ejaculate	☐	Compulsive masturbation	☐	Feelings of inadequacy about sex	☐

Substance Use History

Please complete all that apply				
	Age of 1st use	**When did you last use?** (ex. "1 month ago")	**Frequently of most recent use.** (ex. "3x per week")	**Was this substance ever a problem?** (yes/no)
Alcohol				
Benzodiazepines (Xanax, Valium, etc.)				
Cocaine				
Crack				
Hallucinogens (LSD, mescaline, etc.)				
Heroin				
Inhalants ("Huffing")				
Marijuana				
Methamphetamine				
Methadone				
MDMA ("Ecstasy")				
PCP ("Angel Dust")				
Prescription Medicine (Vicodin, "Oxys", etc.)				
Others:				

Substance Use Assessment C.A.G.E.:	Yes	No
Have you ever felt you should **cut down** on your drinking/using?	[ ]	[ ]
Have you ever felt **annoyed** when people talk about your drinking/using?	[ ]	[ ]
Do you ever feel **guilty** about your drinking/using?	[ ]	[ ]
Do you ever drink/use early in the day, as an **"eye opener"?** (To steady your nerves or make you feel normal?)	[ ]	[ ]

Has drinking or using drugs caused problems in any of the following areas of your life? (Please check all that apply)							
Family	[ ]	Legal	[ ]	Spiritual	[ ]	Social	[ ]
Medical/physical	[ ]	Psychological	[ ]	Financial	[ ]	Job	[ ]
Intellectual	[ ]	Marriage	[ ]	Emotional	[ ]	Personal	[ ]

Legal

Have you ever been arrested for: (Please check all that apply)							
Public Intoxication	[ ]	Driving under the influence	[ ]	Vehicular homicide	[ ]	Sex related crime	[ ]
Driving while intoxicated	[ ]	Drug Abuse	[ ]	Possession of drugs	[ ]	Domestic violence	[ ]

	Yes	No	
Have you ever been convicted of a crime?	[ ]	[ ]	If yes, what was the charge?
Are you presently suing anyone?	[ ]	[ ]	If yes, who?
Is anyone presently suing you?	[ ]	[ ]	If yes, who and why?
Do you have any legal concerns?	[ ]	[ ]	If yes, please describe:
Who is/are your attorney(s)?			

Educational Experience:

Secondary Education: Name of High School and year graduated:	
Or GED [ ] Yes [ ] No	**Year Received:** **Highest grade completed:**

Vocational School Education: Name(s) of school, degree/certification and date received:
College Education: Name(s) of college/university, degree and years received:
Post-Graduate Work: Name(s) of institution, degree and years received:

Work Experience (Please list your last three employers)

Employer/Company:	
Approximate length of employment:	
Reason for leaving:	

Employer/Company:	
Approximate length of employment:	
Reason for leaving:	

Employer/Company:	
Approximate length of employment:	
Reason for leaving:	

Have you ever been fired from a job? If yes, please explain why:

Military History

Have you served in the military? ☐ **Yes** ☐ **No**

If yes, what branch?_____ **Number of years served:**_____

Your highest rank:_____ **Type and date of discharge:** _____

Financial

What's your annual household income?					
No income	☐	$0-$15,000	☐	$16,000-$30,000	☐
$31,000-$49,000	☐	$50,000-$75,000	☐	Over $75,000	☐

The source(s) of my household income is/are:							
Self-earned	☐	Self-earned and spouse	☐	Self and other relative	☐	Retirement income	☐
Welfare	☐	Social Security	☐	Workers Compensation	☐	Private disability	☐

In the past year my current financial situation has:					
Not changed	☐	Increased significantly	☐	Decreased significantly	☐

Are you satisfied with your current financial situation? **Yes** ☐ **No** ☐

Are you currently receiving financial assistance from any of the following sources? (Check all that apply)					
Worker's Compensation	☐	Relatives	☐	Department of Human Services	☐
Supplemental Security Income (SSI)	☐	Social Security Disability (SSD)	☐	Non-relatives (other than salary)	☐

Religion/Spirituality

Atheist (does not believe in God)	☐	Christian Denomination:	☐
Agnostic (doubts whether God exists)	☐	Other Specify:	☐

	Yes	No
Do you attend services regularly?	☐	☐
Do you think (or has anyone ever indicated) you are fanatic about religion?	☐	☐

Spiritual practices: (Please check all that apply)			
Prayer	☐	Meditation	☐
Yoga	☐	Participate in a support group (such as a 12 step program)	☐
Other, please specify:			

Socialization

Please list any hobbies and leisure activities you enjoy:

Do you feel you have adequate social skills? Yes ☐ No ☐ If not, please explain:

What type of Social Media do you use? (Please check all that apply)							
Facebook	☐	Twitter	☐	Instagram	☐	Other: _____	

Thank you for taking the time to complete this packet! Please use the back of this sheet if you have anything that you would like to discuss that was not covered in this packet or if you need to list any additional medications!

_____ _____

Patient Signature Date