

Crosspointe Family Services--Patient Demographics

Please fill out front and back of Form.

Patient Information	Last Name: _____ First: _____ Middle: _____		
	Street Address: _____		
	City: _____	State: _____	Zip: _____ Cell Phone: _____
	Soc. Sec. #: _____	Date of Birth: _____	Age: _____ Sex: M F
	E-mail: _____		Marital Status: _____

Custodian/Guardian Information FOR YOUTH 18 or Younger	Who does the client live with? Name: _____		
	Address: _____		Phone: _____
	Does this person have the legal authority to consent for treatment? Yes No		
	If Yes, circle one: Biological/Adoptive Parent Legal Guardian Foster Parent IDHW Caseworker		
	If No, who has this authority? Name _____ Phone: _____		
Address: _____		City: _____ State: _____ Zip: _____	
**We are unable to see a youth client without the consent of the legal parent/guardian/custodian.			

Other Information	Occupation: _____	Preferred Language: _____	
	Employer: _____	Communication Needs: _____	
	Employer Address: _____	Spouse: _____	
	Work Phone: _____	Race: Circle Answers Ethnicity:	
	Referring Source: _____	1 American Indian/Alaskan Native	1 Hispanic
		2 Asian	2 Non-Hispanic
	What are we seeing you for? _____	3 Black or African American	
		4 Native Hawaii/ Pacific Islander	
	5 White or Caucasian		
	6 Prefer not to answer		

Responsible Party Information	Responsible Party: _____ D.O.B. _____ Soc. Sec. #: _____	
	Address: _____ Phone: _____	
	Relationship: _____	Occupation: _____
	Employer: _____	Work Phone: _____

Insurance Information	Policy Holder: _____ D.O.B. _____	
	Medical Insurance: _____	
	Address: _____ Phone: _____	
	City: _____	State: _____ Zip: _____ E-mail: _____
	Policy #: _____	Medicaid #: _____
	Group #: _____	Medicare #: _____

Emergency Information	IN CASE OF EMERGENCY CONTACT (Person <u>NOT LIVING</u> with patient).			
	Contact Name: _____	Relationship to Patient: _____		
	Address: _____		Phone: _____	
City: _____		State: _____	Zip: _____	Cell Phone: _____

Insurance payments are considered a method of reimbursement to the insured participant for fees paid to Crosspointe and is not a substitute for payment. We do not accept this amount as "payment in full" (unless otherwise restricted by law or agreement with your insurer). IN ORDER TO MAINTAIN COSTS WE ASK THAT OUR CHARGES AND COPAYS BE PAID AT THE TIME OF EACH VISIT. In the event the account is turned over for collection, you agree to pay all collection fees and/or legal fees including attorney fees.

I hereby assign all medical and mental health benefits to which I'm entitled including Medicaid, Medicare, private insurance and other health plans to Crosspointe Family Services. This assignment will remain in effect until revoked by me. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment for services I recieved via Facsimile, hard copy, or electronically.

Patient Signature: _____

Date: _____

Guardian Signature: _____

Date: _____



CROSSPOINTE
FAMILY SERVICES

ACKNOWLEDGEMENT

I acknowledge that I have read, reviewed, and was offered a copy of the following Crosspointe Terms and Conditions for Treatment.

1. Notice of Privacy Practices
2. Informed Consent for Treatment
3. Participants Rights and Grievance Procedure
4. Patient Authorization for Third Party Payor Reimbursement of Provider and Other Verification
5. Other Terms and Conditions

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Agency Witness: _____

07/2018

CR SSPOINTE FAMILY SERVICES

Patient Name: _____ **Date:** _____ **Birthdate:** _____

List all **ALLERGIES** you have: _____

List all **MEDICATIONS** you take: _____

List all Herbal **Supplements and Vitamins** you take: _____

List any previous significant **TRAUMA**: _____

Indicate any **SURGERIES** you have had:

- | | | | |
|--|----------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Hernia | <input type="checkbox"/> Uterus | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Tonsils | <input type="checkbox"/> Tubes Tied | <input type="checkbox"/> None |
| <input type="checkbox"/> List Other: _____ | | | |

Do **You** have any of the the following medical problems?

- | | | | |
|--|--------------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Asthma/Lung | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> List other: _____ | | | |

Do any of the following Medical problems run in your **FAMILY**?

- | | | | |
|--|------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Asthma/Lung | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> List Other: _____ | | | |

Do you Smoke? Yes No
Packs per day? _____ Years? _____

Do you drink Alcohol Yes No
Type and Number of drinks per day _____

Do You now or have you ever used or taken any drugs not prescribed by a doctor?

- No
 Yes Please list: _____

Do You use smokless tobbaoco/chew? Yes No

Form H 8/14

Check any you have had recently or concerns:

- | | |
|---|--|
| <input type="checkbox"/> Low Energy Level | <input type="checkbox"/> Excessive Sleeping |
| <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Recent Vision Changes |
| <input type="checkbox"/> Excessive Sadness | <input type="checkbox"/> Trembling/Shaking |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Over Use of Laxatives |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Aggression |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Easily Distracted |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Victim of Crime | <input type="checkbox"/> Hair Pulling |
| <input type="checkbox"/> Excessive Anger | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Self Injury | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Excessive Worry |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Unexplained Pain |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Change of Libido |
| <input type="checkbox"/> # of Pregancies: | <input type="checkbox"/> # of Children: |

Who is your primary care doctor/provider?

When was your last vist with your primary provider?

Who else manages your medical and/or behavioral health care: Provider Name/City

Comments:



CROSSPOINTE

FAMILY SERVICES

At Crosspointe Family Services we want to ensure that we are coordinating your care with all of your providers. Please tell us who is involved in your medical and behavioral health care. We believe that working together as a care team on your behalf provides the greatest care to you.

Patient's Name _____ **B-Day** _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Provider Name _____ Specialty _____

Facility Name _____ City _____

Thank you for your help!

If you have any questions or concerns about how we coordinate your care or how we use the information please contact:

Mark Gritton
208-736-7090

We respect and protect your patient rights.

Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301
Office: (208)-736-7090 Fax: (208)-736-7089

MEDICAL-Release and/or Exchange of Protected Health Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I DECLINE TO RELEASE ANY INFORMATION TO: _____

I authorize:

Name/Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

(Initial either or both as needed.) _____ to release PHI information to: _____ to obtain PHI information from: _____

Crosspointe Family Services

1363 Fillmore St

Twin Falls, ID 83301

Office: (208)-736-7090 Fax: (208)-736-7089

A. The confidential Protected Health Information (PHI) to be released: (Initial)

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Coordination of Care Communication
<input type="checkbox"/> Last Office Progress Note	<input type="checkbox"/> Pharmacy/Medication List	<input type="checkbox"/> Entire Medical Record
<input type="checkbox"/> Progress Notes: from _____ to _____	<input type="checkbox"/> Medication List(s)	<input type="checkbox"/> Parent/Guardian Communication
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Comprehensive Diagnostic Assessment	<input type="checkbox"/> Care Plan
<input type="checkbox"/> Other: _____		

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but not limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

B. Effective date of authorization:

This authorization takes effect the day that you sign it and terminates on: _____ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

Participant/Guardian Signature Date

Witness Signature Date

NO SHOW/MISSED APPOINTMENT POLICY

Definitions:

No Call/No Show: *ANY missed appointment that isn't canceled with at least 24 hours' notice.*

- If you call the day of your appointment, it is considered a No Call/No Show.
- If you do not show up for your appointment, it is considered a No Call/No Show.
- If you are more than 15 minutes late for your appointment, it is considered a No Call/No Show.

Adequate Communication: *Calling AT LEAST 24 hours in advance to cancel or change an appointment.*

- When you call with at least 24 hours' notice, we are able to allow another client to fill your appointment.

Emergency: An emergency is a situation in which you have absolutely no control or choice.

- If you are in a car accident, that is an emergency.
- If you are in the emergency room or at urgent care, that is an emergency.
- If your car battery is dead when you try to start your car, that is an emergency.
- If someone in your immediate family dies, that is an emergency.

We, at **Crosspointe Family Services**, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling **208-736-7090**.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or text to you is made/attempted one (1) business day prior to your scheduled appointment. Please arrive for your appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. If necessary, please cancel or change your appointment with at least a 24 hours' notice; there is a waiting list to see the clinicians at **Crosspointe Family Services** and, whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than 24 hours is given to cancel or change an appointment, this will be documented as a "No Call/No Show" appointment.
3. If you do not show up to the office for your appointment, this will be a "No Call/No Show" appointment.
4. After the first "No Call/No Show" appointment, you will receive a phone call or letter warning that you have broken our "No Call/No Show" policy. **Crosspointe Family Services** will assist you to reschedule this appointment, if needed.
5. After the 2nd "No Call/No Show" appointment, you will be removed from your counselor's schedule and will only be able to make a return appointment with that counselor's approval. You will not be able to make an appointment with any other clinician in our office.

I have read and understand Crosspointe Family Services' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Crosspointe Family Services appropriately if I have difficulty keeping my scheduled appointments.

Patient Name

Date of Birth

Date

Patient Signature or Parent/Guardian if minor

Relationship to Patient

Staff Signature

Date

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally, (b) you witnessed it happen to someone else, (c) you learned about it happening to someone close to you, (d) you're not sure if it fits, or (e) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

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

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
 In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?						
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	