Evergreen
Youth & Family Services
Strengthening Youth. Preserving Families.

Mailing Address: 610 Patriot Dr NW P.O. Box 662 Bemidji MN 56619

Phone: (218) 751-8223 **Fax:** (218) 751-8070

Mental Health Application

Client #_____

Client Name: _____ Date: _____

Are you your own legal guardian? ☐ Yes ☐ No if no, who is your legal guardian? _____

Former Name/Maiden Name: _____ Sex: ☐ Male ☐ Female ☐ unspecified

SSN: _____ Date of Birth: _____ Age: _____ County of Residence: _____

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

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Ok to call/leave message? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Reminders on days before appointment:
- ○ 1 day before appointment
- ○ 2 days before appointment
- ○ 3 days before appointment

Reminders on day of the appointment:
- ○ Do not send on day of appointment
- ○ At least 2 hours before the appointment

Send appointment reminders to:
- ○ SMS Text (mobile phone) _____-_____-_____
- ○ E-mail address _____

Employment: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Unemployed

Employer: _____ Occupation: _____

Name of person completing form (if different from above): _____

Race/Ethnicity *(check all that apply)*: ☐ Asian ☐ Black/African American ☐ Latino/Hispanic ☐ Native American/Native Alaskan ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Bi/multi-racial

Enrolled in reservation? ☐ Yes ☐ No If yes, where? _____

Emergency contact name: _____ Phone: _____

Relationship to emergency contact person: _____

Do you have Mental Health Care Directive (living will)? ☐ Yes ☐ No

Do you have any special difficulty with reading or writing? _____

Do you have physical disabilities which require that you receive assistance with daily activities? ☐ Yes ☐ No

Do you have any problems that might interfere with your receiving services here at Evergreen YFS? ☐ Yes ☐ No

If yes, please explain: _____

Who referred you to Evergreen YFS? _____

Current living situation: ☐ Alone ☐ With relatives ☐ With non-related

Residence: ☐ Shelter/Homeless ☐ Private residence ☐ Facility ☐ Other_____

Marital Status: ☐ Married/Committed ☐ Widowed ☐ Divorced ☐ Separated ☐ Single/Never married

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People living in the same household:

Name	Age	Relationship	M/F	Employer	Phone
Name	Age	Relationship	M/F	Employer	Phone
Name	Age	Relationship	M/F	Employer	Phone

PROBLEM DESCRIPTION:

Please describe the problem(s) that brings you to Evergreen at this time: _____

_____

_____

What would you like to see change by coming here? _____

_____

Has there been mental health services involved before? ☐ Yes No ☐

If yes, where and when? _____

LEGAL ISSUES

Are you on probation or parole? ☐ Yes ☐ No P.O.: _____

How many charges: _____ Specific Offense: _____

Is this evaluation court ordered? ☐ Yes ☐ No If yes, by which county: _____

Have you been involved in any of the following?

- Worker's Compensation Claim ☐ Yes ☐ No
- Initiating a law suit against another party ☐ Yes ☐ No
- Being sued by another party ☐ Yes ☐ No
- Commitment for mental health or other reasons ☐ Yes ☐ No

Were any of the charges related to chemical abuse? ☐ Yes ☐ No

Are you currently waiting charges, trial or sentencing? ☐ Yes ☐ No

Yes, for: _____

ALCOHOL AND OTHER DRUG INFORMATION

Have you received services for alcohol and/or drug problems in the past? ☐ Yes ☐ No

If yes, where: _____

Number of admissions for detoxification: _____

Number of prior admissions for treatment: _____

Alcohol

☐ Never Used

First Time Used (age): _____ First Time Used to Intoxication: _____

Last Use: _____ Last Used to Intoxication: _____

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Frequency and Amount: _____

Marijuana and Other Drug Use:

☐ No Other Drug Use

Other Drugs Used: _____

First Time Used (age): _____ Last Time used: _____

Frequency and Amount: _____

Misuse or Abuse of Prescription Drugs: _____

Have there been any negative events which have occurred during alcohol or drug use? ☐ Yes ☐ No
If yes, please explain: _____

Do you have a supportive family/social network for recovery? ☐ Yes ☐ No

Do you use caffeine? ☐ Yes ☐ No How much: _____ How often: _____
Do you use tobacco? ☐ Yes ☐ No How much: _____ How often: _____
Do you have problems with gambling? ☐ Yes ☐ No

If yes, please describe: _____

ALCOHOL AND OTHER DRUG INFORMATION, CON'T

Have you ever felt you ought to cut down your drinking or drug use? ☐ Yes ☐ No
Have you ever had people annoy you by criticizing 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 as an eye-opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started? ☐ Yes ☐ No

Please mark all of the items below that apply to you. Check the one that is more important.

☐ Stress, coping with daily roles
☐ Concern about children, child management, parenting
☐ Relationship/family problems
☐ Work problems, workaholic, can't keep a job
☐ Financial or money worries
☐ Self-esteem, sensitive to rejection or criticism
☐ Loneliness, withdrawal, isolations
☐ Motivation, laziness, procrastination
☐ Panic or anxiety attacks
☐ Obsessions, compulsions (repeated thoughts/actions)
☐ Suspiciousness
☐ Delusions (false ideas), thought confusion
☐ Judgment concerns: risk taking, impulsivity
☐ Anger management, outbursts, aggression
☐ Weight and diet issues
☐ Menstrual problems, PMS, menopause
☐ Sexual issues (dysfunction, conflicts, desire differences)
☐ Perpetrator of sexual abuse
☐ Grieving, mourning, deaths, losses
☐ Other _____

Have you experienced past suicide attempts/thoughts (please describe date and method):

How: _____

When: _____

SCHOOL/WORK

Level of Education Years: _____ Degree: _____

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Current Employment/School: _____

Education and/or Career Goals: _____

MEDICAL

Who is your medical doctor? _____

Are you being seen by an Alternative Healer, if so, who? _____

When was your last physical exam? _____ Results: _____

Emergency Room visit in the last year? ☐ Yes ☐ No If yes, why: _____

Are you allergic to or ever had an adverse reaction to any medications? ☐ Yes ☐ No

If yes, please list: _____

Do you have any other allergies? ☐ Yes ☐ No

For example: foods, airborne _____

Have you been treated for any medical concerns? ☐ Yes ☐ No

If yes, please explain: _____

LIST OF SURGERIES THAT YOU HAVE HAD

SURGERY	YEAR

MEDICATIONS

CURRENT MEDICATION	DOSAGE	PRESCRIBER

Have you experienced a traumatic event? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

_____

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Client #_____

Consent for Treatment & Authorization Form

Evergreen staff looks forward to helping you reach your goals. This form requests information to better serve you. All information between provider and patient is held strictly confidential unless you authorize release of confidential information; you present physical danger to yourself or other(s); or child/elder abuse or neglect is suspected. I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

I. **Receipt of Required Notices:** I hereby acknowledge that I have received a copy of Evergreen Youth & Family Services' (EYS) Notice of Privacy Practices and a copy of your Additional Rights (Equal Access, Quality Treatment and Privacy, etc.).

II. **Consent for treatment and use of personal health information (PHI):** I acknowledge that I have consented to receive mental health and related services from the staff of EYS which will be described in full in the treatment planning process. I understand that I must consent to receive services or I will not be served. I further acknowledge that I consent that my PHI, including information regarding chemical dependency, may be used for treatment, payment, or service referrals, subject to the uses and limitations set forth in state and federal law. Any additional uses of my PHI beyond those which are provided for in state and federal law shall require my authorization.

In some instances, counseling services may be covered by grant sources but if you do have insurance, we are required to use that source first and request that you please present that information. If applicable, upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and EYS will be paid directly by the carrier. Please note that Evergreen has a policy that we will cover costs not paid by insurance companies for mental health services.

Client Name: _____ **DOB:** _____

Guardian/Legal Custodian Name (if applicable): _____

Mailing Address - City, State, Zip: _____ Phone: _____

Tribal Affiliation (if applicable): _____

Medical Assistance / MA # (if applicable): _____

Medical Insurance/ Carrier (Primary): _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber Address: _____

Employer: _____ Group # _____ Policy # _____

Medical Insurance/ Carrier (Secondary): _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber Address: _____

Employer: _____ Group # _____ Policy # _____

FOR GRANT FUNDING PURPOSES please place an "X" here if any of the following may apply to you: _____Juvenile involvement such as misdemeanor, felony, probation history, juvenile detention center, chemical dependency center, court-ordered for mental health treatment, etc.

Primary Physician: _____**Clinic/Hospital:** _____**Phone:** _____

Client Signature_____ **Date:** _____

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Parent/Guardian Signature _____ **Date:** _____

I, _____, authorize the release of information regarding my care to my health plan for the payment of claims, certifications/ case management decisions, and other purposes related to the administration of benefits for my health plan.
I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and agree to all of the above information.

Client Name – Printed	Signature	Date

Parent/Guardian Name – Printed	Signature	Date

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AUTHORIZATION TO RECEIVE OR DISCLOSE CONFIDENTIAL INFORMATION

I understand that records are protected under the law and may not be disclosed without written permission or as provided by law.

Client name_____ D.O.B._____

I, _____, (client / parent or guardian if client is a minor)

authorize Evergreen Youth & Family Services, Inc.:

___to receive information from ____ to disclose information

Individual or Agency: _____
Mental Health

Address: _____

This information is for (specify purpose)___Coordination of Services_____

The information shall be limited to (check all that apply):

___ Family / Social History	___ Medical Records	___ Chemical Dependency
___ Psychological/Psychiatric	___ Assessment/Treatment	___ Educational Records
___ Evaluations / Reports	___ Treatment Summary	___ Diagnostic Assessment
___ Employment Records	___ Other (Specify):_____	

I understand that I do not have to sign this authorization and that refusal to sign will not affect my eligibility to receive services.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken and / or information has been disclosed prior to my written revocation.

I also understand that once Evergreen Youth & Family Services, Inc., has disclosed information that I have authorized to be disclosed, Evergreen YFS no longer has control over the information and the information might be re-disclosed by the person or agency I authorized to receive the information.

This authorization automatically expires one year from the date of signing or under the following conditions (specify):_____

_____ _____
Signature of Client Date

_____ _____
Parent or Guardian Date

_____ _____
Witness Date

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NOTICE OF PRIVACY PRACTICES
Effective Date: August 23, 2013

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Evergreen Youth & Family Services is permitted to make uses and disclosures of protected health information for Treatment, Payment and Health Care Operation as described in the following examples:

Treatment: We may use information about you in order to provide treatment or services. We may disclose or share information about you with any of the staff at the mental health center involved in your care. Different programs at the mental health center may need to share information about you in order to coordinate the care you receive. For instance, a psychiatrist may share information about medications you are taking with your therapist or your case manager my alert your psychiatrist about side effects you are experiencing.

Payment: We may use information about you to help obtain payment for services rendered to you. This information may be shared internally between staff such as the reception staff telling your therapist that your insurance plan provides for ten visits or your therapist telling the billing staff your diagnosis in order to include this on the billing form. We will also share information with insurance companies if you authorize your insurance company to be billed such as our providing a diagnosis or a list of the specific services you have received in order to obtain payment.

Health Care Operations: We may use information about you with our staff in order to help coordinate your care or to direct our staff and make sure supplies and other resources are available. For instance, we may review your records to monitor our quality of care and your documentation of your care; we may involve support staff in your care to type clinical records or to schedule your services; we may use your case as a discussion point in clinical meetings where cases are reviewed and discussed.

Besides the uses described for treatment, payment, and operations, Evergreen Youth & Family Services is permitted or required, under specific circumstances, to use or disclose an individual's protected health information at other times without the individual's written authorization. Some examples of these are:

Health Oversight Activities: We may disclose information to a government group to allow them to monitor the health care system. Examples would be license surveys, audits, investigations, inspections, and compliance with civil rights.

Lawsuits and Law Enforcement Request: If you are involved in a lawsuit, we may disclose information about you in response to a court order. If we are presented with a court order we will provide information to law enforcement about you.

Protection of Vulnerable Persons: We may reveal information about you if there is a necessity to report abuse of a child or vulnerable adults.

National Security: If required by law we may reveal information about you to federal officials involved in national security or federal protective services.

Other Legal Disclosures: If state or federal law compels Evergreen Youth & Family Services to release information, we will release it.

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. Written authorizations will be valid for one year, after which time they will need to be renewed if they are to continue. This is true even for individuals who die, their written authorizations continue to the end of the year they were in effect.

Evergreen Youth & Family Services may contact individual clients to provide appointment reminders or information about treatment or alternative treatments or other health related benefits and services that may be of interest to the individual.

Individuals have the following rights regarding protected health information:

Restrictions: The right to request restrictions on certain uses and disclosures of protected health information. Evergreen Youth & Family Services is not required to agree to a requested restriction, however.

Confidential Communications: The right to receive confidential communications of protected health information, as applicable.

Inspect and Copy: The right to inspect and receive a copy of protected health information, as provided in the Privacy Regulation. You may be charged a fee for this service.

Amend: The right to amend protected health information, as provided in the Privacy Regulation.

Accounting of Disclosures: The right to receive and accounting of disclosure of protected health information.

Right to Obtain Notice: The right to obtain a paper copy of this Notice from the covered entity upon request.

Evergreen Youth & Family Services is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. This Notice of Privacy Practices fulfills this purpose.

Evergreen Youth & Family Services will provide all new clients with a copy of this Notice of Privacy Practices when they are completing the registration process before their first service. This may be delayed in instances where individuals are so upset that this would be impractical or unsafe. In these instances, as soon as the individual is calmer, this Notice will be given.

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Evergreen Youth & Family Services is required to abide by the terms of the Notice currently in effect.

Evergreen Youth & Family Services reserves the right to changes the terms of this Notice. Evergreen Youth & Family Services reserves the right to make new Notice provisions effective for all protected health information that it maintains or to apply it only to new information obtained or created after the date of the change in the Notice.

Evergreen Youth & Family Services will provide individuals or clients with a revised Notice by posting the new Notice in the lobby of its offices. Any person may ask for a copy of the new Notice.

Evergreen Youth & Family Services will provide written copies of the Notice and will have electronic versions available on Microsoft Work for email. Also, copies will be available on Evergreen's web page at www.evergreenhouse.org.

Individuals may complain to Evergreen Youth & Family Services and to the Secretary of the Department of Health and Human Services without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows:

1. Make your complaint known to agency staff involved with your care or in the reception area and ask for a remedy.
2. If you are unsatisfied with the resolution of your complaint, ask to have a form to put your complaint into writing.
3. Your complaint will be logged and then directed to the Executive Director.
4. If you are afraid to address your complaint to persons involved in your care then do not do so; instead ask the reception staff for a complaint form. You are not required to address the persons involved with your care regarding your complaint unless you are comfortable doing so.

You may complain if you believe your privacy rights have been violated. You cannot be denied service or treated badly because you have made a complaint.

Please address complaints to:

Evergreen Youth & Family Services
Executive Director
PO Box 662
Bemidji, MN 56619
1-218-751-8223 ext. 119

Or you may choose to contact your state agency at:

MN Department of Human Services
Attn: Privacy Official
PO Box 64998
St. Paul, MN 55164-0998

Or you may choose to contact your federal civil rights office at:

US Department of Health & Human Services
Office for Civil Rights, Region V
223 N. Michigan Avenue, Suite 240
Chicago, IL 60601
1-312-866-2359 or 1-800-368-1019 or 1-866-282-0659

Evergreen Youth & Family Services elects to limit the uses or disclosures that it is permitted to make, as follows: Other uses and disclosure of information not covered in this Notice or the laws that apply to its use will be made only with your written permission. If you provide us permission to use or disclose information you may revoke that permission, in writing, at any time.

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ADDITIONAL CLIENT RIGHTS

QUALITY TREATMENT:
Evergreen Youth & Family Services is a non-profit organization committed to serving the mental health needs of citizens in the Beltrami, Cass, Clearwater, and Hubbard county area.

EQUAL ACCESS:
Evergreen Youth & Family Services provides equal access to employment, programs, and services without regard to race, color, creed, religion, age, sex, handicap, marital status, sexual orientation, HIV status, public assistance, criminal record, or national origin. As required by section 5604 of the Rehabilitation Act of 1973, EYFS provides a procedure to resolve complaints of discrimination on the basis of handicap. If you believe you have been discriminated against by us, contact the Executive Director or Board Chairman by phone or letter.

MINOR RIGHTS:
If you are a minor, you have a legal right to request that information about you not be shared with your parents. You will need to make this request in writing, state your reasons for withholding this information, and show that you understand the consequences of doing so. In a few cases we can withhold this information without your formal request. Feel free to discuss this with your counselor.

TREATMENT PLANNING AND GOALS:
You have the right and responsibility to participate in helping determine your treatment plan and reaching your goals. If you feel you have not been allowed to help in this process, or that a change in counselors might be helpful to you, please advise your counselor or contact the Executive Director.

SUPPLYING INFORMATION:
You have the right to refuse to supply the information we request. However, without certain information, we may not be able to provide you with services. If you feel certain information that we request is an unwarranted invasion of privacy, please ask us for clarification.

STAFF RIGHTS:
Staff has the right:

- To their personal life and to respect for their personal privacy;
- To courtesy and freedom from verbal abuse, harassment, and threats;
- To your full cooperation and full participation in the therapy process;
- To your reliability and promptness in keeping your appointments, and to 24 hour notice when cancellations are unavoidable;
- To terminate treatment or recommend a transfer if reasonable progress is not being made.