MENTAL HEALTH WELLNESS CENTER LLC

Patient Information:

First name	**M**	**Last Name**	
Street Address	**City**	**State**	**Zip**
Please provide only phone numbers where we can leave confidential voicemails that may include medical information or appointment information. This should be a phone number where only you or anyone you are comfortable with hearing this information, has access to.			
Cell Phone	**Home Phone**	**Work Phone**	
Which method(s) would you prefer we use to remind you of your appointment? Please check all the apply:	**Phone**	**Text**	**Email**
Email address			
If you provide your e-mail address we will send you an invitation to register for the MHWC (valant) patient portal. The portal can be used to request an appointment, billing, and for non-emergency medical questions.			
Gender	**Marital Status**	**Date of Birth**	**SSN**
Ethnicity	**Race**	**Preferred language**	
Occupation	**Employer**		

Emergency Contact Information: Parent /Guardian /Spouse /Domestic Partner Information (Circle appropriate designation)

First Name	**Middle Name**	**Last Name**	
Employer	**Date of Birth**	**Social Security #**	
Address(if different from Patient)	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Work Phone**	**OK to Call at Work?**

Primary Medical Insurance/Workmens' Compensation Insurance: please provide all insurance cards

Insurance Company Name		**Member ID#**		**Group #**
Street Address	**City**	**State**	**Zip**	**Phone**
Name of Subscriber		**Subscriber Social Security #**		**Subscriber Date of Birth**
Workmens' Compensation Only	**Date of Accident:**		**Claim's Adjuster Name:**	

Release and Statement to Permit Payment of Private Insurance Benefits to Mental Health Wellness Center LLC

I hereby authorize Mental Health Wellness Center LLC and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges. I authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I authorize and request that payment of any third party or insurance company benefits be made directly to Mental Health Wellness Center LLC for any services furnished to the patient. The signature below shall suffice for all insurance forms on a continuing basis.

Signature _____ Date _____

MENTAL HEALTH WELLNESS CENTER LLC

Consent and Authorization for Treatment

Patient Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

I, _____, authorize and request that Mental Health Wellness Center LLC provide treatment and/or diagnostic procedures, which now or during the course of my care as a patient are advisable. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. I understand that the frequency and type of treatment will be decided between me and the therapist.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

I understand that this consent form will be valid and remain in effect as long as I receive care at Mental Health Wellness Center LLC.

If I have any questions regarding this consent form or about the services offered at Mental Health Wellness Center LLC, I may discuss them with my therapist/clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Mental Health Wellness Center LLC.

Comments: _____

_____ _____

Signature of Patient or Person Authorized to Consent for Patient Date:

If the patient is a minor or is unable to consent, please complete the following:

___ Patient is a minor and is _____ years of age.

Father's Name: _____ Mother's Name: _____

Patient is unable to consent because : _____

MENTAL HEALTH WELLNESS CENTER LLC

Notice of Privacy Practices

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

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, evaluations and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, and from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of Mental Health Wellness Center LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's Public Health Department.

Other uses and disclosures require your authorization, disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, our decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Use of Information. Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the Federal Privacy Standards. These include:

- The right to request restriction on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Mental Health Wellness Center LLC Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changed in Federal and State laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by Federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices or privacy rights that have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address below.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practice is:

Office Manager
Mental Health Wellness Center LLC
3855 Foothills Rd, Suite C
Las Cruces, NM 88011

Effective Date
This Notice is effective on or after February 19, 2018.

Mental Health Wellness Center LLC reserves the right to modify the privacy practices outlined in this notice. I have received a copy of the Notice of Privacy Practices at Mental Health Wellness Center LLC

_____	_____
Printed Name of Patient	Printed Name of Patient Representative*
_____	_____
Signature of Patient	Signature of Representative*
_____	
Date	

*Required if the patient is a minor or an adult who is unable to sign this form

Confidentiality – The laws of the State of New Mexico require issues discussed between the Patient-Therapist be strictly confidential, and not to be shared with anyone (i.e. spouse, physician, family member, teacher, government official, attorney, parent, guardian, etc.) without the express written consent of you, the patient. The only circumstances which may be waived are if your therapist determines you are in eminent danger to yourself or someone else or may be aware of, or acquainted with, someone who may be endangering a child. These two instances will be reported to State authorities and/or the identified victim.

MENTAL HEALTH WELLNESS CENTER LLC

Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable State law governing healthcare information that relates to mental health services and under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2), and cannot be released without my consent. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve (12) months from the date signed.

I, _____ hereby authorize _____
Print Patient's Name Print Treating Provider's Name

Please check one:

_____ To release any applicable information to my Primary Care Physician

_____ To release medication information only to my Primary Care Physician

_____ Not to release information to my Primary Care Physician

_____ _____
Patient or Patient's Guardian Signature Date

_____
Patient or Patient's Guardian Printed Name

Primary Care Physician's Name, Address and Phone Number

_____

_____

MENTAL HEALTH WELLNESS CENTER LLC

Appointment Cancellation and Financial Policy

In order to ensure the effective scheduling and patient flow, Mental Health Wellness Center LLC requires a 24-hour cancellation notice for all scheduled appointments. It is important to us that you keep your appointments to better help you with your mental health needs. As a courtesy, we will call, text or email you to remind you of your appointment. A $25.00 charge will be billed directly to you and not your insurance company if you fail to show or cancel a scheduled appointment with less than 24-hours' notice without the presence of an emergency that could not be avoided. The determination of an "emergency" shall be at the sole discretion of Mental Health Wellness Center LLC. Mental Health Wellness Center LLC reserves the right to terminate services due to 3 consecutive or a history of missed appointments.

Full payment of co-payment for services is expected before each visit, unless prior arrangements have been made. Future appointments will not be given if your payment is not received at time of services. Large delinquent account balances will result in no further appointments until such balances are lowered or paid in full.

We strongly suggest you make an appointment after each session. Clients who have not been seen in over six months as a result of missed or failure to make an appointment may be required to receive a full re-examination to update important clinical information before further care can be provided.

Thank you for your cooperation and understanding. Feel free to call our office anytime with questions or concerns: 575-520-2861.
I have ready and fully understand this policy.

Print Name of Patient	**Date**
Signature of Patient	**Date of Birth**
Mental Health Wellness Center LLC Representative	**Date**

Every phone call is important to us and we attempt to answer all calls and return all phone messages as promptly as possible. Phone messages will be returned on the same or following business day, as soon as the provider/therapist is available. All messages are reviewed by the provider/therapist, however, the call may be returned by a staff member.

Please be aware that the providers/therapists will not leave their scheduled patients to return routine phone calls; these are generally answered after patient care sessions are finished.

If you are experiencing a life-threatening medical emergency, call:

911

For mental health crisis intervention assistance after normal business hours, please call:
The CALL (local 24-hour crisis hotline): **575-646-2255** or **1-866-314-6841** - Spanish Speaking: **1-888-628-9454**
National Suicide Prevention Hotlines: **1-800-784-2433** (Suicide) or **1-800-273-8255** (Talk)
Veterans' Crisis Line: **1-800-273-8255, press 1**
CrisisChat.org for online emotional support
Crisis Text Line: Text **START** to **741-741**
Mesilla Valley Hospital: 3751 Del Rey Blvd, **575-382-3500**
New Mexico State University Counseling Center: **575-646-2731**, Garcia Annex, Room 100, open M-F, 9 am to 5 pm for walk-in crisis services
Please notify us as soon as possible if you have been to the emergency room or received out-of-area care.

Patient Signature	Date

MENTAL HEALTH WELLNESS CENTER LLC

New Patient Questionnaire

Name: _____ Date: _____

Patient Date of Birth: _____ Phone #: _____

1. Reason for seeking services at Mental Health Wellness Center: _____

_____

2. Have you in the past seen a mental health provider: If yes, please name: _____

_____

3. Are you currently seeing a mental health provider: If yes, please name: _____

_____

4. Are you currently taking prescribed medications? Yes or No.

   If Yes, What are they? Who prescribed them? _____

_____

5. Do you or anyone in your family or friends feel you have a drug problem? Yes or No

6. Are you involved in any legal proceeding (Workman's Comp., Disability, Divorce, etc.) Yes or No

   If Yes; briefly explain: _____

_____

_____

7. Who referred you to our office? _____

8. Who is your insurance carrier? _____

TELEMEDICINE PROGRAM

TELEMEDICINE PATIENT CONSENT FORM

I, (name of Patient/Guardian)_____,agree to participate in a telemedicine evaluation and ongoing treatment. By signing this agreement, I authorize the electronic transmission of my medical information and/or video-conference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [**Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause delay in my care and that I may still pursue a face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at the consulting site facility.

Signature or patient/Guardian_____Date_____

Please print the above name_____

I have chosen not to participate in a telemedicine evaluation or follow-up sessions.

Signature of patient/guardian_____Date_____