PROMISE COMMUNITY HEALTH CENTER
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33 4th Street NW, Sioux Center, Iowa 51250 | 712-722-1700 | care@promisechc.org | promisechc.org

MENTAL HEALTH PACKETS – 12 +

1. Welcome Letter
2. Mental Health Agreement
3. Minor Consent
4. Telehealth Consent
5. Release of Info Consent
6. RMS
7. GAD-7
8. PHQ-9
9. BSDS
10. ZANARINI
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Dear New Patient:

We welcome you to the practice of Emily Leinen, PMHNP. We appreciate the confidence you place in us as one of your health care providers, and thank you for choosing Promise.

We have some important reminders to inform you of so you can have an excellent experience while visiting our office. You are very important to us, and each appointment is valuable.

- We ask that you arrive 20 minutes before your scheduled appointment.
- As a Psych NP, Emily is considered a specialty practice. While billing will be handled the same, your copay or deductible may be a little higher.
- If you need to cancel or reschedule, please call us at 712-722-1700 as soon as possible. Missing three appointments—by no-show, late arrival (15+ minutes), or late cancellation—may end your care with Emily Leinen, PMHNP. This helps us respect your time, your provider's time, and others waiting for care.
- PMHNP office hours are as follows:
  - Tuesday – Friday 8am to 5pm.
- Refills will be completed during office hours only
- Please park in the parking lot across the street from Promise

Enclosed you will find new patient paperwork. Please return completed paperwork to our office via mail, email, or by dropping it off at our office. Once we have received your completed paperwork, the nurse will reach out to you to schedule an appointment.

Email: medicalrecords@promisechc.org
Mail: 33 4th Street NW
Attn: Medical Records
Sioux Center, IA 51250

You will be receiving a reminder call or text from our automated service prior to your appointment. If you have any questions, please feel free to call our office at 712-722-1700. We look forward to meeting you.

Emily Leinen, PMHNP

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Psychiatric Mental Health Patient Agreement

At Promise Community Health, we understand that sometimes unexpected event or emergencies may prevent you from attending your scheduled appointment. However, due to the high demand for our services, we ask that you kindly respect the following agreement to ensure that we can provide timely care for all our patients.

Our Promise as the Psychiatric Mental Health Provider:

- Provide high quality, evidence-based psychiatric care
- Provide a caring environment where you feel heard and understood
- Create a holistic treatment plan that is patient centered
- Provide a courtesy reminder all 2 days before your scheduled appointment as well as other reminders and follow up communication as needed.

Your Promise as the Psychiatric Mental Health Patient

- Provide accurate health, personal, financial, and insurance information for best care to include
    - Current and up to date phone numbers
    - Home address where we can best contact you
- Confirm and attend scheduled appointments, arriving on time
    - Appointments require a minimum of 48 hours (2 business days) notice for cancellation or rescheduling
    - Arriving 15 minutes late for and appointment is considered a non-attended appointment and need to be rescheduled
- Understand the Missed appointments affect your treatment and takes away the opportunity for another patient to be seen. This agreement is designed to respect everyone's time, including yours, your provider's, and others in need of an appointment.
- Understand that missing 3 appointments will result in the termination of your professional relationship with Emily Leinen, PMHNP. You may be eligible to re-establish a relationship with Emily Leinen, PMHNP again after 6 months from the last non attended appointment. This waiting period ensures we can maintain availability for patients in need of care.
- A non-attended appointment is defined as:
    - Not attending a scheduled appointment
    - Arriving late
    - Cancelling less than 2 business days before the scheduled appointment
    - Rescheduling more than 3 times
- Understand that rescheduled appointment must be attended within 30 days of the original appointment date.

This agreement is in place to respect three key individuals: you (the patient), your provider, and other individuals who are waiting to be seen. We appreciate your understanding and cooperation.

We value your time and ours, and we appreciate your understanding and cooperation in adhering to this agreement. If you have any questions or need further clarification, please do not hesitate to reach out and ask.

Signature: _____ Date: _____

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MINOR CONSENT FORM

Patient Name: _____ Patient DOB: _____

I _____ (parent/guardian name) am the lawful guardian of the patient listed and there are no court orders now in effect that would prohibit me from conferring the power to consent for patient to be seen and treated. I give consent for patient to be seen and treated for appointment with:

Provider: _____ Appointment date: _____

I give permission that patient will attend the appointment (choose one):

- ☐ Without an adult present
- ☐ Accompanied by another adult:

Full Name: _____ Relationship to Patient: _____

I hereby authorize and appoint person named above as the adult who, in my absence, shall be authorized to consent for all reasonable and necessary medical/health care/dental or behavioral health and/or surgical treatment and/or other procedures which are required during my absence for the above named and described minor child. In consideration of the services that are rendered to said minor named above, I agree to pay for all such services.

I give consent for child to receive vaccines as recommended by provider:

- ☐ Yes
- ☐ No

I give consent for this authorization to be effective for the timeframe of:

- ☐ Above appointment date only
- ☐ Six months from appointment date
- ☐ Other specified dates, not to exceed six months: _____

This authorization shall be effective as specified above. Consent may apply to a different date from if above appointment is rescheduled. This consent may terminate early by my notifying Promise CHC that I wish to revoke it.

_____ _____

Signature of Parent/Legal Guardian Date

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Informed Consent for Telehealth Services

Patient Name: _____ DOB: _____

Purpose: I authorize Promise Community Health Center, as well as any staff, to provide telehealth services for the purpose of mental health services and/or medical services, including assessment, treatment, follow-up, and educational purposes. I understand that Promise Community Health Center will be utilizing telehealth for my treatment care. I authorize Promise Community Health Center to send an electronic link to the email or cell phone number that I provide for access.

Nature of Telehealth: Telehealth uses two-way, real-time interactive communication between the patient and practitioner at a distant site with interactive live two-way audio and video. Telehealth, in the state of Iowa, does not include services through audio-only telephone, electronic mail message, or facsimile services. Telehealth must use a HIPAA-compliant platform that enables patients and providers to connect via encrypted real-time video interaction.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with the telehealth services, and all existing confidentiality protections under federal and Iowa state law apply to information disclosed during telehealth services. The provider will offer telehealth through an approved practice location. The patient may be at any location (in the state of Iowa) when providing telehealth. Please consider your environment for security and confidentiality. I agree that my provider has discussed these precautions with me.

Rights: You may withhold or withdraw consent to the telehealth services at any time without it affecting your future care or treatment, or risking the loss or withdrawal of any service benefits to which you would otherwise be entitled.

For Medical visits: I understand that a limited examination may take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting healthcare provider.

Expected Benefits:

- Improved access to care
- Obtaining expertise from a provider at a distant location

Potential Risks: As with any service provision, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution quality)
- Delays in evaluation or treatment could occur due to deficiencies or failures of the equipment
- Software systems could fail, causing a breach of privacy of personal information
- An insurance provider may or may not cover telehealth services, and therefore, service costs may be incurred

If you need continued non-therapeutic conversation, consider the following advocacy resources:

- Mental Health Hotline 1-800-273-8255
- Iowa Victims Call Center 1-800-770-1650
- Text Victims Help Line IOWAHELP to #20121

In case of emergency, please dial 9-1-1 for continuity of medical care; do not use telehealth services.

I acknowledge that I am advised of all the potential risks, consequences, and benefits of telehealth services. I have had the opportunity to ask questions about the information provided on this form and the services therein.

All my questions have been answered, and I understand the written information provided above. I hereby authorize the use of telehealth services as indicated above, and I agree to participate in and pay for telehealth services. I acknowledge that I may receive a copy of this document upon request.

Patient Signature or Parent/Legal Guardian (if child is a minor): _____ Date: _____

Witness Signature: _____ Date: _____

Iowa state law, passed under HF 2305, allows, "[A]policy, contract, or pain providing for third-party payment or prepayment of health or medical expenses shall not discriminate between coverage benefits of health care services that are provided in person and the same health care services that are delivered through telehealth." This law takes effect January 1, 2019.

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CONSENT FOR RELEASE OF INFORMATION

Request Date: _____ Patient Name: _____ Birth Date: _____

I hereby authorize Promise Community Health Center to release any information, including diagnosis and records of any treatment or examination rendered to me. In addition, I also authorize return release of information to Promise Community Health Center from the referral Individual, agency or other entity listed below.

Name of Person of Institution Telephone

Complete Mailing Address/Street/PO Box City State Zip Code

Check all information to be disclosed – Information will be limited to the prior two (2) years, unless otherwise specified.

☐ Birth records, metabolic & hearing screen results ☐ Mammogram_____

☐ EKG (most recent) ☐ CT/MRI_____

☐ Progress notes/Office visits – Date range: _____ (two years if not specified)

☐ Lab results – Please specify type and approximate Date: _____

☐ Dental records

☐ Other – Please specify type and approximate Date: _____

In the following manner:

☐ Mail ☐ Fax ☐ Other_____

☐ Copies to be picked up by_____

As per my request, reason for release of information is:

☐ Copy for Self -Referral ☐ Transition of care ☐ Insurance ☐ Legal

☐ Other (please specify) _____

Specific Authorization for Release of Information Protected by State or Federal Law

I authorize the release of the information listed below, which requires specific consent under Federal and State Law.

(Must initial any category that may be released)

Substance abuse_____ Mental Health_____ HIV related information _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Promise Community Health Center, I understand that any release that was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized redisclosure and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Promise Community Health Center. A photocopy or fax of this authorization is as valid as the original.

I understand that Promise Community Health Center may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

This agreement will expire one (1) year from the date of signature, unless previously revoked or otherwise indicated.

_____ _____

Signature of patient or legal guardian Date

_____ _____

Relationship if not patient Nurse/Witness signature

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RAPID MOOD SCREENER (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the RMS in less than 2 minutes.

Patient Name: _____ Date: _____

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?		
2. Did you have problems with depression before the age of 18?		
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?		
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?		
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?		
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?		

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? Circle your answers.

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T _____ = _____ + _____ + _____)

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Circle your answers.

	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

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Please answer YES or NO on the line following each sentence:

1. Do you notice that your mood and/or energy levels shift drastically from time to time? _____
2. Do you notice that, at times, your mood and/or energy level is very low, and at other times very high? _____
3. During your "low" phases, do you often feel a lack of energy, a need to stay in bed or get extra sleep or little motivation to do things you need to do? _____
4. Do you often put on weight during these periods? _____
5. During low phases, do you often feel "blue," sad all the time, or depressed? _____
6. Sometimes, during these low phases, do you feel hopeless or even suicidal? _____
7. Is your ability to function at work impaired or are you socially impaired? _____
8. Do these low phases typically last for a few weeks, but sometimes they last only a few days? _____
9. Sometimes with this type of pattern, you may experience a period of "normal" mood in between mood swings, during which your mood and energy level feel "right" and your ability to function is not disturbed? _____
10. Do you then notice a marked shift or "switch" in the way you feel? _____
11. Does your energy increase above what is normal for you, and do you often get many things done that you would not ordinarily be able to do? _____
12. Sometimes, during these "high" periods, do you feel as if you have too much energy or feel "hyper"? _____
13. Do you, during these high periods, feel irritable, "on edge," or aggressive? _____
14. Do you, during these high periods, take on too many activities at once? _____
15. During these high periods, do you spend money in ways that cause you trouble? _____
16. Are you more talkative, outgoing, or sexual during these periods? _____
17. Sometimes, does your behavior during these high periods seem strange or annoying to others? _____
18. Do you sometimes get into difficulty with co-workers or the police, during these high periods? _____
19. Sometimes, do you increase your alcohol or non-prescription drug us during these high periods? _____

Now that you have read this passage, please check one of the following four boxes:

☐ This story fits me very well or almost perfectly.

☐ This story fits me fairly well.

☐ This story fits me to some degree, but not in most respects.

☐ This story does not really describe me at all.

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PLEASE INDICATE WHETHER YES OR NO IS THE BEST ANSWER FOR YOU

		1= YES	0= NO
1.	Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?		
2.	Have you deliberately hurt yourself physically (example: punched yourself, cut yourself, burned yourself?) How about a suicide attempt?		
3.	Have you had at least 3 other problems with impulsivity (example: eating binges and spending sprees, drinking too much and verbal outbursts)?		
4.	Have you been extremely moody?		
5.	Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?		
6.	Have you been distrustful of other people?		
7.	Have you frequently felt unreal or as if things around you were unreal?		
8.	Have you chronically felt empty?		
9.	Have you often felt that you had no idea of who you are or that you have no identity?		
10.	Have you made desperate efforts to avoid felling abandoned or being abandoned (example: repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, or clung to them physically)?		

My feelings towards food and body (check all that apply):

☐ - I feel out of control with my eating

☐ - I dislike my body

☐ - I am always trying to control my weight

☐ - I often binge eat and then try to get rid of calories

☐ - I skip meals to control my weight

☐ - I am secretive about my eating

☐ - I get anxious when I don't exercise

☐ - Others say I have lost a lot of weight in a short period of time

☐ - My menstrual periods are irregular or have stopped completely

☐ - I am scared of weight gain

☐ - Sometimes I vomit after eating

☐ - I use diet pills, laxatives or other substances to control my weight

☐ - I believe I am overweight even though others tell me I am not

☐ - I don't deserve to eat and feel guilty if I do

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name: _____ Date: _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					