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

MENTAL HEALTH PACKETS – 7-11

1. Welcome Letter
2. Mental Health Agreement
3. Minor Consent
4. Telehealth Consent
5. Release of Info Consent
6. SMFO – PATIENT
7. SMFO – PARENT
8. SCARED – PATIENT
9. SCARED - PARENT
10. NICHQ

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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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SHORT MOOD AND FEELINGS QUESTIONNAIRE – PATIENT FORM

Name: _____ Date: _____

This form is about how you might have been feeling or acting recently.

Directions: Read each sentence below and check how much you have felt or acted this way in the past 2 weeks.

- If a sentence was true about you most of the time check **TRUE**.
- If a sentence was only sometimes true, check **SOMETIMES**.
- If a sentence was not true about you, check **NOT TRUE**.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy			
2. I didn't enjoy anything at all			
3. I felt so tired I just sat around and did nothing			
4. I was very restless			
5. I felt I was no good anymore			
6. I cried a lot			
7. I found it hard to think properly or concentrate			
8. I hated myself			
9. I was a bad person			
10. I felt lonely			
11. I thought nobody really loved me			
12. I thought I could never be as good as other kids			
13. I did everything wrong			

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SHORT MOOD AND FEELINGS QUESTIONNAIRE – PARENT FORM

Name: _____ Date: _____

This form is about how your child might have been feeling or acting recently.

Directions: Read each sentence below and check how much she or he has felt or acted this way in the past 2 weeks.

- If a sentence was true about your child most of the time check **TRUE**.
- If a sentence was only sometimes true, check **SOMETIMES**.
- If a sentence was not true about your child, check **NOT TRUE**.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy			
2. S/he didn't enjoy anything at all			
3. S/he felt so tired s/he just sat around and did nothing			
4. S/he was very restless			
5. S/he felt s/he was no good anymore			
6. S/he cried a lot			
7. S/he found it hard to think properly or concentrate			
8. S/he hated him/herself			
9. S/he felt s/he was a bad person			
10. S/he felt lonely			
11. S/he thought nobody really loved him/her			
12. S/he thought s/he could never be as good as other kids			
13. S/he felt s/he did everything wrong			

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SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED) – CHILD VERSION – TO BE FILLED OUT BY CHILD

Name: _____ Date: _____

Directions: Read each sentence below and check the box that best describes how you've felt over the past 3 months.

	0 – Not True or Hardly Ever True	1 – Somewhat True or Sometimes True	2 – Very True or Often True
1. When I feel frightened, it is hard for me to breathe			
2. I get headaches when I am at school			
3. I don't like to be with people I don't know well			
4. I get scared if I sleep away from home			
5. I worry about other people liking me			
6. When I get frightened, I feel like passing out			
7. I am nervous			
8. I follow my mother or father wherever they go			
9. People tell me that I look nervous			
10. I feel nervous with people I don't know well			
11. I get stomachaches at school			
12. When I get frightened, I feel like I am going crazy			
13. I worry about sleeping alone			
14. I worry about being as good as other kids			
15. When I get frightened, I feel like things are not real			
16. I have nightmares about something bad happening to my parents			
17. I worry about going to school			
18. When I get frightened, my heart beats fast			
19. I get shaky			
20. I have nightmares about something bad happening to me			
21. I worry about things working out for me			
22. When I get frightened, I sweat a lot			
23. I am a worrier			
24. I get really frightened for no reason at all			
25. I am afraid to be alone in the house			
26. It is hard for me to talk with people I don't know well			
27. When I get frightened, I feel like I am choking			
28. People tell me that I worry too much			
29. I don't like to be away from my family			
30. I am afraid of having anxiety (or panic) attacks			

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31. I worry that something bad might happen to my parents			
32. I feel shy with people I do not know well			
33. I worry about what is going to happen in the future			
34. When I get frightened, I feel like throwing up			
35. I worry about how well I do things			
36. I am scared to go to school			
37. I worry about things that have already happened			
38. When I get frightened, I feel dizzy			
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)			
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I do not know well			
41. I am shy			
TOTALS			

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SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED) – PARENT VERSION – TO BE FILLED OUT BY PARENT

Name: _____ Date: _____

Directions: Read each sentence below and check the box that best describes your child over the past 3 months. Please respond to ALL statements even if it does not seem to concern your child.

	0 – Not True or Hardly Ever True	1 – Somewhat True or Sometimes True	2 – Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe			
2. My child gets headaches when he/she is at school			
3. My child doesn't like to be with people he/she doesn't know well			
4. My child gets scared if he/she sleeps away from home			
5. My child worries about other people liking him/her			
6. When my child gets frightened, he/she feels like passing out			
7. My child is nervous			
8. My child follows me wherever they go			
9. People tell me that my child looks nervous			
10. My child feels nervous with people he/she doesn't know well			
11. My child gets stomachaches at school			
12. When my child gets frightened, he/she feels like he/she is going crazy			
13. My child worries about sleeping alone			
14. My child worries about being as good as other kids			
15. When he/she gets frightened, he/she feels like things are not real			
16. My child has nightmares about something bad happening to his/her parents			
17. My child worries about going to school			
18. When my child gets frightened, his/her heart beats fast			
19. He/she gets shaky			
20. My child has nightmares about something bad happening to him/her			
21. My child worries about things working out for him/her			
22. When my child gets frightened, he/she sweats a lot			
23. My child is a worrier			
24. My child gets really frightened for no reason at all			
25. My child is afraid to be alone in the house			
26. It is hard for my child to talk with people he/she doesn't know well			
27. When my child gets frightened, he/she feels like he/she is choking			
28. People tell me that my child worries too much			
29. My child doesn't like to be away from his/her family			

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30. My child is afraid of having anxiety (or panic) attacks			
31. My child worries that something bad might happen to his/her parents			
32. My child feels shy with people he/she doesn't know well			
33. My child worries about what is going to happen in the future			
34. When my child gets frightened, he/she feels like throwing up			
35. My child worries about how well he/she does things			
36. My child is scared to go to school			
37. My child worries about things that have already happened			
38. When my child gets frightened, he/she feels dizzy			
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)			
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she does not know well			
41. My child is shy			
TOTALS			

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

11-19/rev1102