The Center for Emotional Care
400 East Burwell Street
Salem, VA 24153
540-387-3105

Thank you for choosing The Center for Emotional Care as the provider for your mental health services. We are dedicated to caring for you in a kind, respectful, and professional manner and we hope your experience with us will be both pleasant and beneficial.

With this letter, you will find a *New Patient Information Packet*. Please fill out the packet as completely as possible and mail it back to our office at least seven days prior to your appointment date **or** bring it with you to your initial appointment. (If you do not attend your first appointment or do not reschedule within 30 days, your Information Packet will be properly destroyed.)

Please arrive **at least 15 minutes** prior to your appointment time with the completed paperwork. If you misplace the paperwork, you must arrive 45 minutes prior to your appointment time to complete a new packet. Arriving late may result in your appointment being rescheduled. If you miss the appointment or arrive late you may be charged a fee. Please also read the included *Policies and Procedures* portion of your packet. It contains helpful information about our practice and how we do business. As always, the management, providers and staff are happy to speak with you about any questions or concerns you may have.

How to get to The Center:

- From Interstate 81 take **EXIT 140**
- Take **ROUTE 311 SOUTH** (Thompson Memorial Drive) to Salem
- At the second traffic light turn **RIGHT** onto **Main Street**
- At the next traffic light turn **LEFT** onto **South College Avenue**
- At the next traffic light turn **LEFT** onto **Thompson Memorial Drive**
- Bare **RIGHT** onto **East Burwell Street**
- The Center is located in the tan building on the right behind College Lutheran Church

What to bring with you to your appointment:

1. CURRENT INSURANCE CARD
    - We need an actual copy of your insurance card in order to accurately process your claims. If you do not provide this information you will be financially responsible for the complete cost of your visits.
2. METHOD OF PAYMENT
    - Cash, Check, or Debit/Credit Card (we gladly accept Mastercard and Visa)
3. PHOTO ID
4. ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING

Again, feel free to call us at 540-387-3105 if you have any questions or concerns before your first appointment. Thank you for your confidence and we look forward to serving the needs of you and/or your family.

Sincerely,

Management and Staff
The Center for Emotional Care

The Center for Emotional Care

ADULT PATIENT REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is This Your Legal Name? ❑ Yes ❑ No	If Not, What Is Your Legal Name?	Birth Date: / /	Age:	Gender: ❑ M ❑ F Other:_________

Mailing Address:	Social Security #:	Home Phone No.: ( )

Address Continued:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone No.: ( )

How Were You Referred To The Center?	❑ Primary Care Physician	❑ Other Doctor/Therapist	❑ Yellow Pages/Telephone Book	Other:_____________

Race : ❑ Caucasian ❑ Black or African American ❑ Hispanic ❑ Asian ❑ American Indian or Alaska Native ❑ Other:_____________

Preferred Language : ❑ English ❑ Spanish ❑ French ❑ German ❑ Vietnamese ❑ Italian ❑ Mandarin ❑ Other:_____________

Ethnicity : ❑ Hispanic or Latino ❑ Other:_____________

INSURANCE AND PAYMENT INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible For Bill:	Birth Date: / /	Address (If Different):	Home Phone No.: ( )

Is This Person A Patient Here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Phone No.: ( )

Is This Patient Covered By Insurance? ❑ Yes ❑ No	Does This Patient Have Secondary Insurance Coverage? ❑ Yes ❑ No

Please Indicate Primary Insurance	

Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-Payment: $

Patient's Relationship To Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name Of Local Friend Or Relative (Not Living At Same Address):	Relationship To Patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Center for Emotional Care, its agents or my insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

FINANCIAL AGREEMENT

IF YOU HAVE COMMERCIAL INSURANCE COVERAGE – we will bill most major insurance carriers for you if you provide the necessary information to us. A copy of your insurance card must be provided in advance of your appointment. We will not back-bill insurance after a date of service, even if insurance information is provided at a later date. Co-payments and deductibles are due at the time of service. Coinsurance will be billed to you once payment is received from your insurance carrier. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If your insurance carrier has not paid within 60 days of billing, any outstanding fees will become due and payable by you.

Assignment of Commercial Insurance Benefits

I hereby assign all health benefits, private insurance, and any other health plans to The Center for Emotional Care and request payment of benefits be made to them on my behalf. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges regardless of whether payment is made by my insurance company. I authorize The Center for Emotional Care to release any information necessary to secure payment for services provided to me.

IF YOU HAVE MEDICARE INSURANCE COVERAGE – we will bill Medicare for you. We will also bill any secondary insurance carrier. Co-payments and deductibles are due at the time of service. Coinsurance will be billed to you once payment is received from your insurance carrier.

Assignment of Medicare Insurance Benefits

I hereby request payment of all Medicare benefits be made on my behalf to The Center for Emotional Care for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

NON-COVERED SERVICES – Any services not paid for by your insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial.

PATIENTS WITHOUT INSURANCE COVERAGE – Lack of insurance coverage will in no way affect the availability or level of care provided to you. By signing below, patients without insurance coverage agree to pay the total amount due on each date of service.

PAYMENT OF OUTSTANDING BALANCES - You are responsible for co-payments or other charges at the time of service. However, coinsurance amounts will often not be reflected on your statement until the following billing cycle. Each month we mail billing statements for each account with balances due. You are responsible for paying the total amount due upon receipt of the statement. If we do not receive payment in full for balances due within 30 days of billing, we will begin collection procedures. Outstanding balances exceeding 60 days past due may result in the suspension of services. Seriously delinquent accounts will be referred to a professional collection agency or the Internal Revenue Service for collection. In the event that your account is forwarded to an external collection agency, any collection fees will be added to your total amount due. You agree that in order for us to service the account or to collect any amounts you may owe, we/or the collection agency may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We or/collection agency may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

SIGNATURE

By signing below, I attest that I have read, understand and will agree to The Center for Emotional Care's financial policies regarding payment for services rendered, including all policies outlined in the Policies and Procedures Packet. By signing I agree to be financially responsible for any and all professional fees.

Patient Name:	
Responsible Party's Name (if different):	
Patient/Responsible Party's Signature:	
Insurance Subscriber's Name (if different):	
Insurance Subscriber's Signature:	

INFORMED CONSENT FOR TREATMENT

Patient Name:		**Date of Birth:**	

By signing below, I hereby give permission to The Center for Emotional Care to provide treatment/testing to the person named above. This will include discussion of tentative diagnosis, methods and modalities to be used in treatment, and possible outcomes. I understand that treatment outcomes cannot be guaranteed, and that treatment can at times be painful and difficult. I understand that I may withdraw from treatment at any time, but I agree to discuss my plan with my therapist/doctor before doing so. I further agree to take medication as prescribed, and will inform my doctor of any side effects immediately.

I further acknowledge that I have read and understand the Policies and Procedures, and that I understand the limits of confidentiality regarding treatment, and the office policies regarding scheduling, emergency coverage, fees and billing, insurance filing, missed appointments, court appearances, copying records, phone consultations, etc… I acknowledge my understanding of and my willingness to abide by these policies and procedures by my signature below.

SIGNATURES

Patient Signature ______________________ ***Date*** __________

Witness Signature ______________________ ***Date*** __________

MEDICAL HISTORY/INFORMATION

Briefly state the reason you would like to see a Psychiatrist/Therapist:		
Primary Care Physician:	Facility:	Phone Number:
Other Psychiatrist/Therapist:	Facility:	Phone Number:

Are you presently taking any prescription medications?	❑ YES	❑ NO

If yes, please list them below:

Medication:	Dosage:	How long have you taken it:	Prescribing Doctor:
Height:	Weight:	When was your last medical exam?	
Do you smoke? ❑ YES ❑ NO	If so, how much?		
Have you ever had a head injury?	If so, when?	Have you ever had a seizure?	If so, when?
Do you have any medication allergies ❑ YES ❑ NO	If so, which?		
Have you previously been treated by a psychiatrist? ❑ YES ❑ NO	If so, when?	Briefly describe the reason:	
Have you previously been treated by a therapist? ❑ YES ❑ NO	If so, when?	Briefly describe the reason:	
Have you ever been hospitalized for psychiatric reasons? ❑ YES ❑ NO	If so, when?	Briefly describe the reason:	

FAMILY HISTORY/INFORMATION

Father's Name:	❑ Living	Occupation:	Age:
	❑ Deceased	Cause of Death:	Age at time of Death:
Mother's Name:	❑ Living	Occupation:	Age:
	❑ Deceased	Cause of Death:	Age at time of Death:
Are/were your parents divorced?	❑ YES	❑ NO	If yes, what age were you when they separated?

List any siblings and their ages:			
List any children and their ages:			
List all current members of your household:			

FAMILY HISTORY/INFORMATION CONTINUED

Please check all that apply:

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS
Alcoholism	❑	❑	❑	❑
Drug Abuse	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Manic Depression	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑
Suicide	❑	❑	❑	❑
ADHD	❑	❑	❑	❑
Obsessive/Compulsive Disorder	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑
Other Disorders	❑	❑	❑	❑

Do you have a history of physical, verbal, or sexual abuse?	❑ YES	❑ NO
If yes, please explain:		
Do you have a history of legal difficulties?	❑ YES	❑ NO
If yes, please explain:		

SUBSTANCE ABUSE HISTORY

Please check all that apply:

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	❑ YES	❑ NO			❑ YES	❑ NO
Barbiturates	❑ YES	❑ NO			❑ YES	❑ NO
Xanax, Valium, Librium	❑ YES	❑ NO			❑ YES	❑ NO
Cocaine, Crack	❑ YES	❑ NO			❑ YES	❑ NO
Heroin, Opiates	❑ YES	❑ NO			❑ YES	❑ NO
Marijuana	❑ YES	❑ NO			❑ YES	❑ NO
PCP, LSD, Mescaline	❑ YES	❑ NO			❑ YES	❑ NO
Inhalants	❑ YES	❑ NO			❑ YES	❑ NO
Caffeine	❑ YES	❑ NO			❑ YES	❑ NO
Nicotine	❑ YES	❑ NO			❑ YES	❑ NO
Amphetamines, Speed, Uppers, Crystal Meth	❑ YES	❑ NO			❑ YES	❑ NO
Designer Drugs, Ecstasy	❑ YES	❑ NO			❑ YES	❑ NO
Over-the-counter drugs	❑ YES	❑ NO			❑ YES	❑ NO
Other	❑ YES	❑ NO			❑ YES	❑ NO

If you currently use any of the above substances, please describe when and where you typically use:

Please describe how your use has affected your family and friends, including how they perceive your use:

How do your perceive your use?

Have you ever received substance abuse treatment?	❑ YES	❑ NO

Have you ever had:	❑ Blackouts	❑ DUI	❑ Seizures	❑ Tremors	❑ Legal Charges	❑ Hallucinations

REPORT OF CURRENT AND PAST SYMPTOMS

Please check any problems that either you have had in the past or are currently having.

Current	Past		Current	Past	
❑	❑	Obsess about checking, counting/or washing hands	❑	❑	Fidgety, restless, overactive
❑	❑	Hear voices	❑	❑	Talking/acting without thinking
❑	❑	Feel people are after you, against you, following you	❑	❑	Short attention span
❑	❑	Unusual thinking	❑	❑	Frequent daydreams
❑	❑	Odd speech/thinking	❑	❑	Self-mutilation
❑	❑	Not interested in making friends	❑	❑	Bored easily
❑	❑	Fear of becoming fat	❑	❑	Vandalism
❑	❑	Engage in self-induced vomiting	❑	❑	Fire-setting
❑	❑	Gorging on food	❑	❑	Nightmares
❑	❑	Excessive dieting/exercise	❑	❑	Afraid to leave a loved one
❑	❑	Use laxatives	❑	❑	Fear of strangers
❑	❑	Eat things that are not food	❑	❑	Often sick on school/work days
❑	❑	Shy	❑	❑	Refusing to talk
❑	❑	Expect failure	❑	❑	Defiant of authority
❑	❑	Selfish	❑	❑	Often disobedient
❑	❑	Lazy	❑	❑	Argumentative/sudden anger
❑	❑	Avoid adults	❑	❑	Upset of minor changes
❑	❑	Easy going	❑	❑	Stubborn
❑	❑	Friendly	❑	❑	Temper tantrums
❑	❑	Enthusiastic	❑	❑	Lack of guilt over wrong doing
❑	❑	Slow moving	❑	❑	Bullies others
❑	❑	Easily embarrassed	❑	❑	Sexually acting out
❑	❑	Few close friends	❑	❑	Lying
❑	❑	Lack of responsiveness to others	❑	❑	Truancy
❑	❑	Messy	❑	❑	Physically aggressive toward others
❑	❑	Careless, reckless	❑	❑	Theft
❑	❑	Learning difficulties	❑	❑	Lack of self-confidence
❑	❑	Difficulty paying attention	❑	❑	Problems with long-term memory
❑	❑	Disorganized	❑	❑	Problems with short-term memory

As you fill out the questionnaire, read each item carefully and check the item that best reflects how you have been feeling during the past few days. Make sure you circle one answer for each question. If more than one answer applies to how you have been feeling, select the higher number. If in doubt, make your best guess. Please do not leave questions unanswered.

Question 1:		Question 2:	
0	I do not feel sad.	0	I am not particularly discouraged about the future.
1	I feel sad.	1	I feel discouraged about the future.
2	I am sad all the time and I can't snap out of it.	2	I feel I have nothing to look forward to.
3	I am so sad of unhappy that I can't stand it.	3	I feel that the future is hopeless and that things cannot improve.

(Questionnaire continued on next page.)

Question 3:		Question 4:	
0	I do not feel like a failure.	0	I get as much satisfaction out of things as I used to.
1	I feel I have failed more than the average person.	1	I don’t enjoy things the way I used to.
2	As I look back on my life, all I can see is a lot of failures.	2	I don’t get real satisfaction out of anything anymore.
3	I feel I am a complete failure as a person.	3	I am dissatisfied or bored with everything.
Question 5:		Question 6:	
0	I don’t feel particularly guilty.	0	I don’t feel I am being punished.
1	I feel guilty a good part of the time.	1	I feel I may be punished.
2	I feel quite guilty most of the time.	2	I expect to be punished.
3	I feel guilty all of the time.	3	I feel I am being punished.
Question 7:		Question 8:	
0	I don’t feel disappointed in myself.	0	I don’t feel I am any worse than anybody else.
1	I am disappointed in myself.	1	I am critical of myself for my weaknesses or mistakes.
2	I am disgusted with myself.	2	I blame myself all the time for my faults.
3	I hate myself.	3	I blame myself for everything bad that happens.
Question 9:		Question 10:	
0	I don’t have any thoughts of killing myself.	0	I don’t cry more than usual.
1	I have thoughts of killing myself, but I would never carry them out.	1	I cry more now than I used to.
2	I would like to kill myself.	2	I cry all the time.
3	I would like to kill myself if I had the chance.	3	I used to be able to cry, but now I can’t cry even though I want to.
Question 11:		Question 12:	
0	I am no more irritated by things than I ever am.	0	I have not lost interest in other people.
1	I am slightly more irritable now than usual.	1	I am less interested in other people than I used to be.
2	I am quite annoyed or irritated a good deal of the time.	2	I have lost most of my interest in other people
3	I feel irritated all the time now.	3	I have lost all of my interest in other people.
Question 13:		Question 14:	
0	I make decisions as well as I ever could.	0	I don’t feel that I look any worse than I used to.
1	I put off making decisions more than I used to.	1	I am worried that I am looking old or unattractive.
2	I have greater difficulty in making decisions than before.	2	I feel that there are permanent changes in my appearance that make me look unattractive.
3	I can’t make decisions at all any more.	3	I believe that I look ugly.
Question 15:		Question 16:	
0	I can work about as well as before.	0	I can sleep as well as usual.
1	It takes an extra effort to get started at doing something.	1	I don’t sleep as well as I used to.
2	I have to push myself very hard to do anything.	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3	I can’t do any work at all.	3	I wake up several hours earlier than I used to and cannot get back to sleep.
Question 17:		Question 18:	
0	I don’t get more tired than usual.	0	My appetite is not worse than usual.
1	I get tired more easily than I used to.	1	My appetite is not as good as it used to be.
2	I get tired from doing almost anything.	2	My appetite is much worse now.
3	I am too tired to do anything.	3	I have no appetite at all anymore.

(Questionnaire continued on next page.)

Question 19:		Question 20:	
0	I haven't lost much weight, if any, lately.	0	I am no more worried about my health than usual.
1	I have lost more than five pounds.	1	I am worried about physical problems such as aches and pains, or upset stomach or constipation.
2	I have lost more than ten pounds.	2	I am very worried about physical problems and it's hard to think of much else.
3	I have lost more than fifteen (15) pounds.	3	I am so worried about my physical problems that I cannot think of anything else.
❑	I am purposely trying to lose weight by eating less		
Question 21:		Question 22:	
0	I have not noticed any recent change in my interest in sex.	0	I have not had any ideas about hurting another person.
1	I am less interested in sex than I used to be.	1	I think sometimes of harming another person, but I would never do it.
2	I am much less interested in sex now.	2	I would like to seriously hurt another person.
3	I have lost interest in sex completely.	3	I would kill someone if I had the chance. That person is _______________.

MOOD DISORDER QUESTIONNAIRE

Please answer each question as honestly as possible.

Has there ever been a period of time when you were not your usual self and…		
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❑ YES	❑ NO
…you were so irritable that you shouted at people or started fights or arguments?	❑ YES	❑ NO
…you felt much more self-confident than usual?	❑ YES	❑ NO
…you got much less sleep than usual and found you didn't really miss it?	❑ YES	❑ NO
…you were much more talkative or spoke faster than usual?	❑ YES	❑ NO
…thoughts raced through your head or you couldn't slow your mind down?	❑ YES	❑ NO
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❑ YES	❑ NO
…you have much more energy than usual?	❑ YES	❑ NO
…you were much more active or did many more things than usual?	❑ YES	❑ NO
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❑ YES	❑ NO
…you were much more interested in sex than usual?	❑ YES	❑ NO
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❑ YES	❑ NO
…spending money got you or your family in trouble?	❑ YES	❑ NO
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❑ YES	❑ NO

How much of a problem did any of these cause you – such as being unable to work; having family, money, or legal troubles, getting into arguments or fights?

❑ No Problem	❑ Minor Problem	❑ Moderate Problem	❑ Serious Problem

BURNS ANXIETY INVENTORY

The symptoms of anxiety can be divided into those affecting feelings, thoughts, and the body. To determine the level of your anxiety, please select the response that best describes how much that symptom or problem has affected you during the past week.

CATEGORY ONE – Anxious Feelings	Not at all	Somewhat	Moderately	A lot
Anxiety, nervousness, worry or fear	❑	❑	❑	❑
Feeling that things around you are strange, unreal, or foggy	❑	❑	❑	❑
Feeling detached from all or part of your body	❑	❑	❑	❑
Sudden, unexpected panic spells	❑	❑	❑	❑
Apprehension or a sense of impending doom	❑	❑	❑	❑

(Questionnaire continued on next page.)

Feeling tense, stressed "uptight", or on edge	❑	❑	❑	❑
CATEGORY TWO – Anxious Thoughts	Not at all	Somewhat	Moderately	A lot
Difficulty Concentrating	❑	❑	❑	❑
Racing thoughts or having your mind jump from one thing to the next	❑	❑	❑	❑
Frightening fantasies or daydreams	❑	❑	❑	❑
Feeling that you're on the verge of losing control	❑	❑	❑	❑
Fears of cracking up or going crazy	❑	❑	❑	❑
Fears of fainting or passing out	❑	❑	❑	❑
Fears of physical illness, heart attacks, or dying	❑	❑	❑	❑
Concerns about looking foolish or inadequate in front of others	❑	❑	❑	❑
Fears of being alone, isolated, or abandoned	❑	❑	❑	❑
Fears of criticism or disapproval	❑	❑	❑	❑
Fears that something terrible is about to happen	❑	❑	❑	❑
CATEGORY THREE – Physical Symptoms	Not at all	Somewhat	Moderately	A lot
Skipping, racing, or pounding of the heart (sometimes called palpitations)	❑	❑	❑	❑
Pain, pressure, or tightness in the chest	❑	❑	❑	❑
Tingling or numbness in the toes or fingers	❑	❑	❑	❑
Butterflies or discomfort in the stomach	❑	❑	❑	❑
Constipation or Diarrhea	❑	❑	❑	❑
Restlessness or jumpiness	❑	❑	❑	❑
Tight, tense muscles	❑	❑	❑	❑
Sweating not brought on by heat	❑	❑	❑	❑
A lump in the throat	❑	❑	❑	❑
Trembling or shaking	❑	❑	❑	❑
Rubbery or "jelly" legs	❑	❑	❑	❑
Feeling dizzy, light-headed, or off balance	❑	❑	❑	❑
Choking or smothering sensations or difficulty breathing	❑	❑	❑	❑
Headaches or pains in the neck or back	❑	❑	❑	❑
Hot flashes or cold chills	❑	❑	❑	❑
Feeling tired, weak, or easily exhausted	❑	❑	❑	❑

MAST DRINKING QUESTIONNAIRE

Please answer each question regarding your drinking patterns as honestly as possible.

Do you enjoy having a drink now and then?	❑ YES	❑ NO
If you checked yes, please continue. If you checked no, please disregard the rest of this questionnaire.		
Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people you know and you have not gotten into any recurring trouble while drinking.)	❑ YES	❑ NO
Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	❑ YES	❑ NO
Do your parents, spouse, friends, or others ever worry or complain about your drinking?	❑ YES	❑ NO
Can you stop drinking without a struggle after 1 or 2 drinks?	❑ YES	❑ NO
Do you feel guilty about your drinking?	❑ YES	❑ NO
Do friends or relatives think you are a normal drinker?	❑ YES	❑ NO
Are you able to stop drinking when you want to?	❑ YES	❑ NO

(Questionnaire continued on next page.)

Have you ever attended a meeting of Alcoholics Anonymous (AA)?	❑ YES	❑ NO
Have you gotten into physical fights when you have been drinking?	❑ YES	❑ NO
Has your drinking ever created a problem between you and your parents, spouse, friends, or others?	❑ YES	❑ NO
Has a family member of yours ever gone to anyone for help about your drinking?	❑ YES	❑ NO
Have you ever lost friends because of your drinking?	❑ YES	❑ NO
Have you gotten into trouble at work or school because of drinking?	❑ YES	❑ NO
Have you ever lost a job because of drinking?	❑ YES	❑ NO
Have you ever neglected your obligations, schoolwork, family, or job for two or more days in a row because you were drinking?	❑ YES	❑ NO
Do you drink before noon fairly often?	❑ YES	❑ NO
Have you ever been told you have liver trouble or Cirrhosis?	❑ YES	❑ NO
After heavy drinking, have you ever had severe shaking, heard voices, or seen things that weren't there?	❑ YES	❑ NO
Have you gone to anyone for help about your drinking?	❑ YES	❑ NO
Have you ever been in a hospital because of drinking?	❑ YES	❑ NO
Have you even been a patient in a psychiatric hospital where drinking was part of the problem that resulted in your hospitalization?	❑ YES	❑ NO
Have you even been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergy for help with any emotional problem where drinking was a part of the problem?	❑ YES	❑ NO
Have you even been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages or any other drug?	❑ YES	❑ NO
Have you ever been arrested, or taken into custody (even for a few hours) because of other drunken behavior, whether due to alcohol or another drug?	❑ YES	❑ NO

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES – In keeping with the provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), The Center for Emotional Care has provided a "Notice of Privacy Practices" to me. By signing below, I acknowledge that I have received, read, and understand this notice.

POLICIES AND PROCEDURES – By signing below, I acknowledge that I have received a copy of The Center for Emotional Care's "Policies and Procedures" and attest that I have read, understand, and will abide by all policies and procedures as outlined.

AUTHORIZATION TO RECEIVE REMINDER CALLS

The Center for Emotional Care provides reminder calls as a courtesy to all patients on the business day previous to their scheduled appointment. In keeping with the provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), The Center for Emotional Care must retain your permission before providing this courtesy service.

By accepting this service and signing below, you are giving The Center for Emotional Care permission to give you a reminder call, including permission to leave a message on your answering machine/voice mail, or with anyone who might answer your telephone. If you do not wish to receive this courtesy service, please select the "decline" option below.

❑	**ACCEPT:** "I would like to receive reminder calls and give permission to The Center for Emotional Care to leave a message for me if I am unavailable."
❑	**DECLINE:** "I would **NOT** like to receive reminder calls and do **NOT** give permission to The Center for Emotional Care to leave a message for me if I am unavailable."

REQUIRED SIGNATURES

Signature of Patient or Legal Guardian ***Date***

Printed Name of Person Signing

Witness ***Date***

The Center for Emotional Care

400 East Burwell Street
Salem, Virginia 24153
Phone: (540) 387-3105 Fax: (540) 387-3653

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a provider's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the prescriber with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that The Center for Emotional Care can request and use your prescription medication history from other health providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to The Center for Emotional Care to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

___________________________	_________________________
Name of Patient	Patient's DOB
___________________________	___________________________
Signature of Patient or Guardian	Date

Relationship to Patient: ____________________

The Center for Emotional Care
400 East Burwell Street
Salem, VA 24153
Phone: 540-387-3105 ~ Fax: 540-387-3653

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Virginia Prescription Monitoring Program

Patient Name: ____ DOB: __________________

Street Address: ____

City: ________________________________ State: _______________ Zip: ________________

I hereby authorize providers at The Center for Emotional Care to request and receive any and all records held by the Virginia Department of Health Professions relating to any and all substances dispensed to the patient named above. I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to The Center for Emotional Care.

I authorize the providers at The Center for Emotional Care to re-release information obtained through the Department of Health Professions to any and all of my treating providers.

I understand that I may refuse to sign this release or revoke this consent at any time, except to the extent that information has already been released, and that this consent will expire at discharge, unless specified differently on this form. I further understand that if I refuse to sign this release or revoke my consent that providers at The Center for Emotional Care may decide not to prescribe addictive substances.

A copy of this authorization shall be included with my original records.

____ ______________________

Signature of Patient Date

____ ______________________

Signature of Witness Date

The Center for Emotional Care
400 East Burwell Street, Salem, VA 24153
Phone: 540-387-3105 Fax: 540-387-3653

Authorization to Use or Disclose My Health Information

Patient Name: ______________________________ DOB: ______________

Patient Address: ____
(Street) (City) (State) (Zip)

Information is to be □ exchanged with or □ released from Providers of The Center for Emotional Care and:

Please fill Out for Primary Care Physician	
Name/Agency:	______________________
Street Address:	______________________
City, State, Zip:	______________________
Phone/Fax Numbers:	______________________

Purpose of Release: □ Diagnosis/Treatment □ Communication □ Legal Representation □ Continuity of Care
□ Other: ______________________________

Reason(s) for this authorization (check all that apply):
□ At my request
□ Other (specify): ______________________________ ____________

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

□ Psychiatric Records □ Alcohol Abuse Treatment Information □ Verbal Treatment Information
□ Psychotherapy Notes □ Drug Abuse Treatment Information □ HIV/AIDS Information
□ Lab Results □ Psychiatric Test Results □ Consultations
□ Any and all health information maintained by The Center for Emotional Care
□ Other: ______________________________

The recipient is authorized to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person to disclose or obtain protected health information. I further acknowledge that:

- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- The original or a copy of this authorization shall be included with my original records.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken on it, by delivering the revocation in writing to the provider who is in possession of my health care records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If not previously revoked, this authorization will expire in: □ One year; □ On (specify date): ______________

______________________________ ______________ ______________
Signature of Adult Patient or Legally Authorized Representative Relationship Date Signed

______________________________ ______________
Signature of Minor Patient (if 14 or older) Date Signed