BORDER AREA MENTAL HEALTH SERVICES, INC.
dba SOUTHWEST COUNSELING CENTER, INC.

Welcome to our agency.

During your initial evaluation with a medical prescriber, any current psychotropic medications you are prescribed will be reviewed. This review may result in either continuing, adjusting or discontinuation. Below are some medications and guidelines before you begin your treatment with us. These controlled substances will be looked at closely.

We may prescribe in **minimal** doses:

Schedule II N
amphetamine (Dexedrine, Adderall)
methamphetamine (Desoxyn)
methylphenidate (Ritalin)

Schedule IV
alprazolam (Xanax)
carisoprodol (Soma)
clonazepam (Klonopin)
clorazepate (Tranxene)
diazepam (Valium)
lorazepam (Ativan)
midazolam (Versed)
temazepam (Restoril)
triazolam (Halcion)

We **do not** prescribe (medications will be tapered off and discontinued):

Schedule II Opiods
Codeine (only available in generic form)
Fentanyl (Actiq, Duragesic, Fentora, Abstral, Onsolis)
Hydrocodone (Hysingla, Zohydro ER)
Hydrocodone/acetaminophen (Lorcet, Lortab, Norco, Vicodin)
Hydromorphone (Dilaudid, Exalgo)
Meperidine (Demerol)
Methadone (Dolophine, Methadose)
Morphine (Kadian, MS Contin, Morphabond)
Oxycodone (OxyContin, Oxaydo)
Oxycodone and acetaminophen (Percocet, Roxicet)
Oxycodone and naloxone

Schedule III
combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin)
products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with codeine)
buprenorphine (Suboxone)

Please let us know if you have any questions. Thank you.

100 W. Griggs Avenue
Las Cruces, NM 88001
575-522-7260 phone
575-522-1355 fax

PO Box 1349
Silver City, NM 88062
575-388-4497 phone
575-597-4499 fax

429 E. Olive Street
Deming, NM 88030
575-546-4497 phone
575-936-4481 fax

401 S Anthony Dr, St G
Anthony, NM 88021
575-388-4497 phone
575-201-5200 fax

BORDER AREA MENTAL HEALTH SERVICES dba SOUTHWEST COUNSELING CENTER
PATIENT/CLIENT DEMOGRAPHIC FORM

REASON FOR VISIT: _____ DATE: _____

Name: (Last, First, M.) _____

Physical Address: _____ PO Box _____

City/State: _____ Zip: _____ E-Mail: _____

Primary Phone: _____ Alternate Phone: _____

Social Security Number: _____ Date of Birth: _____

Gender: Male _ Female Marital Status: Child | Single Married Widowed | Other____

Race: |White | Black/Afr Ame | Asian Amer Ind/Alaska Other Ethnicity: Yes, Hispanic No, Not Hispanic

Employment Status: Unemployed | Full-time _ Part-time | | Disabled | Self-Employed

Live with: _____ Highest level of Education: _____

Are you a Veteran? Yes No | Unknown Primary Language: | English ¯ Spanish ¯ Other

US Citizen? Yes No Unknown Referred by: _____

Insurance: | Yes No Insurance Company: _____

Insurance ID #: _____ Primary Income Source: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Address: _____ Phone: _____

City/State: _____ Zip: _____

LEGAL INFORMATION

Guardianship Status: _____ CYFD Custody Status: _____

Responsible Person: _____ Relationship: _____

Address: _____ City/State/Zip: _____ Phone: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Phone: _____

Address: _____ Pharmacy: _____

City/State: _____ Zip: _____

CONFIDENTIAL HEALTH HISTORY

Name: _____ Date: _____
Birth Date: _____ Age: _____ Date of Last Physical Examination: _____
Date of Last Dental Examination: _____ Date of Last Vision Examination: _____
Reason for visit today: _____

MEDICATIONS: List all medications you are currently taking:	**ALLERGIES**: □ Yes □ No
	LIST ALL:

CURRENT SYMPTOMS: Check (X) symptoms you have currently or in the past year: (*CIRCLE* if still receiving or need treatment)

GENERAL	**GASTROINTESTINAL**	**EYE, EAR, NOSE, THROAT**	**MEN Only**
□ Chills	□ Appetite Poor	□ Bleeding Gums	□ Breast Lump
□ Depression	□ Bloating	□ Blurred Vision	□ Erection Difficulties
□ Dizziness	□ Bowel Changes	□ Crossed Eyes	□ Lump in Testicles
□ Fainting	□ Constipation	□ Difficulty Swallowing	□ Penis Discharge
□ Fever	□ Diarrhea	□ Double Vision	□ Sore on Penis
□ Forgetfulness	□ Excessive Hunger	□ Earache	□ Other
□ Headache	□ Excessive Thirst	□ Ear Discharge	**WOMEN Only**
□ Loss of Sleep	□ Gas	□ Hay Fever	□ Abnormal Pap Smear
□ Loss of Weight	□ Hemorrhoids	□ Hoarseness	□ Bleeding Between Periods
□ Nervousness	□ Indigestion	□ Loss of Hearing	□ Breast Lump
□ Numbness	□ Nausea	□ Nosebleeds	□ Extreme Menstrual Pain
□ Sweats	□ Rectal Bleeding	□ Persistent Cough	□ Hot Flashes
MUSCLE/JOINT/BONE	□ Stomach Pain	□ Ringing in the Ears	□ Nipple Discharge
Pain, weakness, numbness in:	□ Vomiting	□ Sinus Problems	□ Painful Intercourse
□ Arms □ Hips	□ Vomiting Blood	□ Vision-Flashes	□ Vaginal Discharge
□ Back □ Legs	**CARDIOVASCULAR**	□ Vision-Halos	□ Other
□ Feet □ Neck	□ Chest Pain	**SKIN**	Date of last period:
□ Hands □ Shoulders	□ High Blood Pressure	□ Bruise Easily	Date of last pap smear:
GENITAL/URINARY	□ Irregular Heart Beat	□ Hives	Have you had a mammogram?
□ Blood in Urine	□ Low Blood Pressure	□ Itching	Are you pregnant?
□ Frequent Urination	□ Poor Circulation	□ Change in Moles	Number of Children:
□ Lack of Bladder Control	□ Rapid Heartbeat	□ Rash	
□ Painful Urination	□ Swelling of Ankles	□ Scars	
	□ Varicose Veins	□ Sores that won't Heal	

MEDICAL HISTORY: Check (X) the medical conditions you have or have had in the past: (*CIRCLE* if still receiving or need treatment)

□ **AIDS**	□ Chicken Pox	□ **HIV Positive**	□ Rheumatic Fever
□ Alcoholism	□ Diabetes	□ Kidney Disease	□ Scarlet Fever
□ Anemia	□ Emphysema	□ Liver Disease	□ Stroke
□ Anorexia	□ Epilepsy	□ Measles	□ Suicide Attempt
□ Appendicitis	□ Gall Bladder Disease	□ Migraine Headaches	□ Traumatic Brain Injury
□ Arthritis	□ Glaucoma	□ Miscarriage	□ Thyroid Problems
□ Asthma	□ Goiter	□ **Mononucleosis**	□ Tonsillitis
□ Bleeding Disorders	□ **Gonorrhea**	□ Multiple Sclerosis	□ Tuberculosis
□ Breast Lump	□ Gout	□ Mumps	□ Typhoid Fever
□ Bronchitis	□ Heart Disease	□ Pacemaker	□ Ulcers
□ Bulimia	□ Hepatitis (Type:_____)	□ Pneumonia	□ Vaginal Infections
□ Cancer	□ Hernia	□ Polio	□ Venereal Disease
□ Cataracts	□ **Herpes**	□ Prostate Problem	□ Other STD – List:
□ Chemical Dependency	□ High Cholesterol	□ Psychiatric Care	

CONFIDENTIAL HEALTH HISTORY

HOSPITALIZATIONS Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? □ Yes □ No If yes, approximate dates: _____

OCCUPATION CONCERNS Check (X) if your work exposes you to the following:	HEALTH HABITS Check(X) which substances you use and indicate how much you use per day/week:	PREGANCY HISTORY Year of Birth / Sex of Birth / Complications if any		
□ Stress	□ Caffeine			
□ Hazardous Substances	□ Tobacco			
□ Heavy Lifting	□ Drugs			
□ Other:	□ Alcohol			
	□ Injection Drug User			
	□ Sharing of Needles			

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

FAMILY HISTORY: Fill in health information about your family.						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (X) if your blood relative had any of the following: Disease	Relationship to you
Father					□ Arthritis, Gout	
Mother					□ Asthma, Hay Fever	
Brothers					□ Cancer	
					□ Chemical Dependency	
					□ Diabetes	
					□ Heart Disease, Stroke	
Sisters					□ High Blood Pressure	
					□ Kidney Disease	
					□ Tuberculosis	
					□ Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Yes _____ No _____ I consent for my health information to be addressed for support in my treatment at BAMHS (*such as to be addressed in treatment plan, support in coordination for further assessment or accessing related resources, etc.)*

_____ _____

Signature Date

Border Area Mental Health Services, Inc.
dba Southwest Counseling Center, Inc.

MEDICATION QUESTIONNAIRE AND DISCLAIMER (FOR PATIENT)

PLEASE COMPLETE ANY OF THE FOLLOWING MEDICATION YOU ARE CURRENTLY TAKING:

Klonopin/clonazepam: _____mg_____ frequency (how many times a day)

Xanax/alprazolam: _____mg_____ frequency (how many times a day)

Ativan/lorazepam: _____mg_____ frequency (how many times a day)

Valium/diazepam: _____mg_____ frequency (how many times a day)

ACCORDING TO THE AMERICAN PSYCHIATRIC ASSOCIATION (APA):

Benzodiazepines cause acute adverse effects: drowsiness, increased reaction time, ataxia, motor incoordination and anterograde amnesia. Structured detoxification for benzodiazepines requires careful attention to the prevention of seizures, withdrawal delirium and treatment of chronic withdrawal symptoms.

Border Area Mental Health Services, Inc., may determine that the best plan/course of treatment may include detoxification from these substances. In those cases, you will meet and speak with the medical provider and may be encouraged to work in connection with your Primary Care Physician (PCP) or another local medical provider or hospital on a detoxification regime.

Border Area Mental Health Services, Inc., is willing to manage all other psychotropic medications during the detoxification period.

_____ _____

Name – Print DOB

_____ _____

Signature Date

_____ _____

BAMHS Representative Date

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Las Cruces, NM 88001
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BORDER AREA MENTAL HEALTH SERVICES

dba SOUTHWEST COUNSELING CENTER, INC.

Contract for Controlled Substance Prescriptions

Controlled substance medications (i.e. benzodiazepines and stimulants) are very useful, but can be addictive, habit-forming, and have the potential for misuse; therefore, they are controlled by local, state and federal government. They are intended to improve function and/or ability to work, not simply to feel good. By initialing, I am agreeing to comply with the following conditions:

(_____) 1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced or stolen, I understand that it will not be replaced.

(_____) 2. **I will not request or accept controlled substance medication of the same category from any other physician or individual while I am receiving such medication from Border Area Mental Health Services (BAMHS).** Besides being illegal to do so, mixing controlled substances may endanger my health, and possibly lead to death. The only exception is if it is prescribed while I am admitted to a hospital.

(_____) 3. **Refills of controlled substance medication:**

- **a.** I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If I use it up sooner than prescribed, I understand a refill will not be made.
- **b.** If I need a refill of a controlled medication prescription, I understand I must call **at least seventy-two (72) hours** in advance; otherwise a refill will not be made. Refills will not be ordered by phone.
- **c.** I understand that while the office is closed, controlled medications cannot be ordered.
- **d.** **If I miss an appointment, or fail to reschedule my follow-up appointment,** I understand that my controlled medications will not be renewed until I see my physician again.

(_____) 4. I understand that reports of all prescribed controlled substances are available through the Prescription Monitoring Program (PMP) of the New Mexico Board of Pharmacy, and a report may be requested by my prescriber at any time.

(_____) 5. I understand the importance of following my treatment plan as directed by my provider/physician and agree:

- **a.** To keep my appointments (including follow-ups and referrals).
- **b.** To bring my medication bottles to my appointments.
- **c.** To report any medications given from other providers/physicians.
- **d.** To comply with requests for urine toxicology screens.

(_____) 6. If female: I understand that controlled substances present a risk to the fetus if pregnant. I agree:

- **a.** To use contraception, even if not currently in an intimate relationship
- **b.** To stop use of controlled substances and notify my prescriber immediately if pregnancy occurs.

(_____) 7. I understand that if I **violate any of the above conditions,** my controlled substance prescription and/or treatment with BAMHS may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to other healthcare providers, medical facilities, pharmacies and other authorities.

(_____) 8. I understand that the **main treatment goal is to improve my ability to function and/or work.** In consideration of that goal, I agree to abstain from the use of alcohol or "street drugs". I understand that these substances will impact my progress and counter act with any prescribed medications. "Street drugs" are not only mind-altering but also illegal. Continued use of these substances after warning can result in my care being terminated immediately and may be reported to the PMP of the NM Board of Pharmacy.

I have read this contract and fully understand its content. In addition, I fully understand the consequences of violating this contract.

Patient Printed Name:_____ Patient's Signature:_____

Agency's Signature: _____ Date:_____

Border Area Mental Health Services, Inc.
dba Southwest Counseling Center, Inc.

Toxicology Screening Protocol

As our valued patient, we appreciate your patronage at this establishment and would like to continue our partnership with you regarding your mental health treatment goals. We have implemented a toxicology screening program at the recommendation of the NM Department of Health.

This means unannounced urine or oral toxicology screens may be requested of you, and your cooperation is required and appreciated. Failure to comply with this protocol may result in rescheduling of appointments, cessation of prescribed medications and possible discontinuation of treatment.

We look forward to working with you in the future and collectively reaching the goals that we have discussed for your treatment. If you are in agreement with this protocol, please sign your name below:

_____	_____
Name – Print	DOB
_____	_____
Signature	Date
_____	_____
BAMHS Representative	Date

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BORDER AREA MENTAL HEALTH SERVICES, INC. (BAMHS) dba Southwest Counseling Center

Telemedicine/Telehealth Informed Consent

I, _____, hereby consent to participate in telemedicine/telehealth as part of my treatment. I understand that this is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client located in two different locations.

I understand the following with respect to these types of services:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care or services.
2. I understand that there are risks, benefits and consequences associated with telemedicine services, including but not limited to, disruption of transmission by technology failures, interruption and/or possible breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. In the case of technology failures, sessions may need to be rescheduled.
3. There will be no recording of any of the online sessions by either party without written consent. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. The privacy laws that protect the confidentiality of my protected health information also apply to telehealth services.
4. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
5. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
6. Any out-of-pocket costs such as copayments, coinsurances, and deductibles that apply to telemedicine/ telehealth or in-person visits are the patient's responsibility and due upon receipt of service.
7. For cash only patients, we expect the payment for the cost of the service to be paid, up front and in full, prior to receiving the service.
8. Unpaid balances are subject to collection calls after 30 days in arrears. A statement of balance due is sent to the last known address regularly.
9. If you are unable to make it to your scheduled appointments, you are expected to contact the office to give 24 hour notice in order for another individual to be given the cancelled time.

By signing the form, I verify that I have read the above information, have had any questions answered to my satisfaction and agree with the content of this document.

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Staff Signature Date

Border Area Mental Health Services, Inc.
dba Southwest Counseling Center, Inc.

By signing this document, I acknowledge that I have received a copy of the following:

- Notice of Privacy Practices including Confidentiality of Alcohol & Drug Abuse Records
- Appointment Cancellation Policy
- Emergency Numbers
- Client Rights

INSURANCE AUTHORIZATION AND ASSIGNMENT
I HEREBY AUTHORIZE Southwest Counseling Center dba Border Area Mental Health Services to furnish information to my insurance carrier and/or Medicaid concerning my illness and treatment. I understand it is my responsibility to inform the office of any updated information including insurance information. Any information not furnished in a timely manner, may cause a self pay fee to be assessed.

PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT
I request that payment of authorized Medicare or Medicaid benefits be made either to me or on my behalf for any services furnished by me including physician services. I authorize any holder of medical and other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

RESPONSIBILITY TO PAY CHARGES
I agree to pay all deductibles and/or co-pays in accordance with my health plan (if applicable), or the self pay rate. I agree to pay this fee at the time of service or within 30 days thereafter. I understand that my information may be given to a third party to collect on a delinquent account.

RESPONSIBILITY AND CONDUCT
Your responsibility is to fully report circumstances affecting your treatment, subsequent changes that might alter your treatment, and to cooperate fully in your treatment process.

The patients/clients of Southwest Counseling Center, Inc. (SWCC) dba Border Area Mental Health Services, Inc. (BAMHS) are expected to display the same reasonable and prudent behavior appropriate to the setting and the circumstances as would be expected of any citizen of the state. In a clinical setting, expressions of anger and/or sorrow or grief are appropriate; it is the degree and manner which these strong emotions are expressed that may lead to problems. In all cases, your behavior may not violate New Mexico State Statutes, especially as these relate to harm or potential harm to self, or the person or property of others. BAMHS reserves the right to terminate treatment at any time with required notice based on any verbal or non-verbal aggression.

Authorization of Services: I hereby request SWCC/BAMHS to provide services as deemed necessary, reasonable, and appropriate. This includes, but is not limited to, evaluation, treatment and referral.

I have received a copy of the materials listed above and these materials have been discussed with me. In addition, the Agency's staff has disclosed in plain language the nature of the treatment offered by the agency, alternatives available, and the risks of not receiving treatment. I understand and accept these disclosures and processes and hereby voluntarily consent to participate in the admission, assessment, and intake process. I understand that I may revoke this consent at any time without penalty.

_____	_____	_____
Name (Print)	Signature	Date
_____	_____	_____
Staff Member (Print)	Signature	Date

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ID #: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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**
_____	_____	_____	_____

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Name: Date:

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. 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?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Name: _____DOB:_____Date:_____

VULNERABILITY TO ABUSE SCREENING SCALE (VASS)

Purpose: To identify individuals at risk of elder abuse through a self-report instrument.

Instructions: Please just answer "yes" or "no".

1. Are you afraid of anyone in your family? Yes ____ No ____
2. Has anyone close to you tried to hurt you or harm you recently? Yes ____ No ____
3. Has anyone close to you called you names or put you down or made you feel bad recently? Yes ____ No ____
4. Do you have enough privacy at home? Yes _ No _
5. Do you trust most of the people in your family? Yes ____ No ____
6. Can you take your own medication and get around by yourself? Yes ____ No ____
7. Are you sad or lonely often? Yes ____ No ____
8. Do you feel that nobody wants you around? Yes ____ No _
9. Do you feel uncomfortable with anyone in your family? Yes ____ No ____
10. Does someone in your family make you stay in bed or tell you you're sick when you know you're not? Yes _ No ____
11. Has anyone forced you to do things you didn't want to do? Yes ____ No ____
12. Has anyone taken things that belong to you without your OK? Yes ____ No ____

Schofield, M. J., & Mishra, G. D. (2003). Validity of self-report screening scale for elder abuse: Women's Health Australia Study. *The Gerontologist, 43*(1), 110-120, Table 1.

Special Consent for Release of Sensitive Information

BORDER AREA MENTAL HEALTH SERVICES, INC. dba SOUTHWEST COUNSELING CENTER, INC.

Client Name:		Other Names:
DOB:	Address:	Phone Number:

Purposes for Release

The purpose of this Consent is to request and authorize Border Area Mental Health Services/Southwest Counseling Center to use the Collective Platform to electronically transmit and disclose the sensitive information described below to past, present, or future members of my Care Team through the Collective Network for purposes of enabling members of my Care Team to provide Treatment to me. (See reverse side for answers to some Frequently Asked Questions).

Consent to Release Sensitive Information

I hereby request and authorize Border Area Mental Health Services/Southwest Counseling Center to disclose my sensitive information and records as described below through the Collective Platform operated by Collective Medical Technologies, Inc. to the members of my Care Team identified below who are connected to or participate in the Collective Network. This consent and request applies to information and records concerning diagnosis and treatment of me as a minor, if applicable.

Amount and Kind of Sensitive Information to be Disclosed [Check **ONE** of the following boxes]

☐ Option #1: Full Care Documentation. Any of the following types of sensitive information or records which are available in Border Area Mental Health Services/Southwest Counseling Center's electronic record (e.g., clinical notes, discharge summaries, care plans, lab results, medications, etc.) to my Care Team for purposes of providing me Treatment, including:

- Substance use (alcohol or drug) diagnosis and treatment information and any information related to my treatment at, or any records from, any substance use disorder program (including medications, treatment plans, clinical assessments or tests, symptoms, diagnoses, progress notes, etc.)
- HIV/AIDS or sexually transmitted disease (STD) diagnosis or treatment information and records
- Mental health, behavioral health, and developmental disability diagnosis and treatment information and records, whether on an inpatient or outpatient, or voluntary or involuntary basis
- Adult day program service information

☐ Option #2: Limited Care Team & Care Encounter Information. Only my sensitive information limited to identifying: (1) the type of providers who are members of my Care Team, such as providers that specialize in substance use (alcohol or drug) treatment or referral services, mental health (inpatient or outpatient, HIV or sexually transmitted diseases, developmental disability services, adult day programs and Social Services Providers; **AND** (2) the dates, locations, and types of encounters with such providers (e.g., associated diagnosis, complaint, service or location codes or information, etc.).

To Whom My Sensitive Information May be Disclosed

The sensitive information and records described above may be disclosed to all of the past, present, and future members of my Care Team (including Health Care Providers, Behavioral Health Providers, and Social Service Providers), which may access my sensitive information indicated above to enable them to provide Treatment to me as part of my overall Care Plan.

I understand that:

- I am authorizing Border Area Mental Health Services/Southwest Counseling Center to disclose the sensitive information I have designated above, for the purposes and to the parties described in this Consent.
- My decision to sign this Consent is voluntary, and I understand that I may refuse to sign this Consent. My refusal to sign will not affect my ability to obtain Treatment or payment or my eligibility for benefits.
- As required under federal law (42 CFR Part 2, § 2.13(d)), upon my request Border Area Mental Health Services/Southwest Counseling Center will provide me with a list of entities to which my sensitive information has been disclosed under this Consent.
- I understand that I have a right to receive a copy of this Consent.
- I understand that I may revoke (i.e., take back) my Consent in writing at any time. My revocation will take effect upon receipt by Border Area Mental Health Services/Southwest Counseling Center, except to the extent that others have already acted in reliance upon this Consent.
- My Consent will expire either upon my death, or if and when I decide to revoke it.

Client Signature:		Date:
Legal Representative (if any)	Signature:	Name:
Reason Client is unable to sign (if applicable):		
Relationship to Client: Parent Guardian/Conservator Health Care Power of Attorney __ Other Legally Authorized Representative under applicable state law (specify: _____)		

Definitions and Frequently Asked Questions

Border Area Mental Health Services, Inc./Southwest Counseling Center, Inc.

What is the Collective Network?

Border Area Mental Health Services/Southwest Counseling Center participates in the network operated by Collective Medical Technologies, Inc. ("Collective") which connects Health Care Providers, Behavioral Health Providers, Social Service Providers, and managed care and other health Insurance Organizations ("Collective Network"). The Collective Network enables health care providers and organizations to connect and collaborate by sharing electronic health information for their shared patients through Collective Medical's software applications so they can better coordinate their efforts to provide safe, convenient, integrated care to you.

What is the Collective Platform?

The "Collective Platform" is a technology platform underlying a suite of software applications which enables health care providers to share historical summaries about your health care visits, recommendations for how to best meet your needs when you visit a health care provider, contact information of your health care providers, and other information that can help you Care Team about certain health care events, like when you have an emergency department visit, or when you have been discharged from the hospital after an inpatient stay.

Who is my Care Team?

Your "Care Team" includes your past, current, or future treating providers who have attested to Collective that they have a treating provider relationship with you. Your Care Team may include a variety of health care professionals or facilities, such as "Health Care Providers" which are authorized under state law to provide health care or medical services (e.g., doctors, nurses, pharmacists, hospitals, health center, etc.), "Behavioral Health Providers" authorized under state law to provide mental health or substance use disorder or referral services (e.g., psychiatrists, psychologists, counselors, other mental health professionals or substance use counselors, certain social workers, etc.) or "Social Service Providers" authorized under state law to provide diagnosis, evaluation, treatment, or consultation services (e.g., social workers, nurses, or other individuals with such professional licensure or credentials as required under state law).

What kind of activities does the term "Treatment" include?

The term "Treatment" includes activities related to the provision or coordination of health care and related services by one or more members of our Care Team, including referral or consultation for any condition for which you may receive care, including medical, mental health, or substance use disorder. Your Care Team may work with you to develop a plan of care (or "Care Plan") that includes a summary of your diagnosis, treatment goals, and treatment activities. Treatment activities can include sharing your information as may be necessary for your Care Team to provide a referral, conduct an evaluation, provide updates about your health care encounters or visits or new services, programs, or benefits for which you are eligible, or sharing changes or updates to your Care Plan.

Why doesn't the Special Consent Form cover my general medical information?

HIPAA and applicable state privacy laws permit Collective to enable health care organizations which have a relationship with you, and which participate in the Collective Network to use the Collective Platform to share your general medical information for treatment, payment, or health care operations purposes (as those terms are defined by HIPAA) without your specific authorization or consent. Collective and the health care organizations that have a relationship with you cannot share certain categories of your "sensitive information" that are protected under state or federal law, unless you sign a specific consent form which meeting applicable legal requirements. The purpose of this Special Consent Form is to enable you to authorize members of your Care Team to have access to this sensitive information to better enable members of your Care Team to provide Treatment to you.

Am I required to participate in the Collective Network or can I opt-out?

Your participation is voluntary, and you may refuse to allow your information to be shared through the Collective Platform. You may choose not to sign this Special Consent Form; in which case your Care Team will not be able to share your sensitive information between the Collective Platform. You may also choose to "opt-out" of allowing Collective to Share your general medical information between health care organizations you work with. If you are interested in learning more about opting-out, ask Border Area Mental Health Services/Southwest Counseling Center for more information about opting-out of the Collective Network.

Will signing this Special Consent Form affect other consents or authorizations I have signed?

You may have signed other consent or authorization forms, and your signing this special Consent Form does not limit or revoke those other consents or authorizations.

BORDER AREA MENTAL HEALTH SERVICES, INC. (BAMHS)
P.O. Box 1349
Silver City, New Mexico 88062
(575) 388-4497 (ph) (575) 597-4499 (fax)

Use of Text Messaging for Client Communications Informed Consent Form

This agreement for the use of text messaging for client communications is between Border Area Mental Health Services, Inc. and an individual client or ___other individual/ organization_____(Name of Organization or Individual).

As a client of BAMHS, I choose to communicate with the agency staff by ___Text Message.

I choose to both send and receive the following types of messages:

___Appointment Only General Information ___Other/Protected Health Information

____ None

I understand that text messaging systems are not secure and there is some possibility that the confidentiality of such communications will be breached by a third party.

I understand that BAMHS cannot guarantee that the privacy/confidentiality of information communicated by text message can be maintained. Communications regarding highly confidential behavioral health/medical matters should therefore be reserved for other forms of communication (e.g., telephone, personal visit).

I agree that text messaging communications with BAMHS are offered as a convenience to me, and I shall not hold BAMHS responsible for any expense, loss, or damage caused by, or resulting from: (i) a delay in BAMHS response to me, or any damage to me resulting from such a delay, due to technical failures including, but not limited to, technical failures attributable BAMHS' cell phone internet service provider, power outages, failure of BAMHS' electronic messaging software, failure by BAMHS' or me, to properly address text messages, failure of BAMHS' cell phones, computers, or computer network, or faulty telephone or cable data transmission; (ii) any interception of my text message communications or BAMHS' text message communications by a third party; or (iii) my failure to comply with the guidelines regarding us of text message communications set forth below.

I agree and understand that I may use text messaging to communicate with BAMHS regarding my care and treatment and with BAMHS regarding certain administrative matters arising from treatment services rendered to me. However, I shall not use text messaging to communicate with BAMHS and shall use other means of communication (e.g., telephone, personal visit) for:

a. Emergencies or other time-sensitive issues,
b. Inquiries which deal with sensitive information, and
c. Situations in which BAMHS response is delayed.

I understand that I may change my preferred communication methods at any time by notifying BAMHS staff verbally, in writing or by email.

For questions or additional information, I understand that I may contact a staff member at (575) 388-4497 (this number cannot receive/send texts).

My signature below indicates that I have decided to use the communication method checked above and that I have read and understand the information provided above.

_____
Printed Name of Client

_____ _____
Client signature Date

Notified by Client to discontinue the following way to communicate with BAMHS staff:

___ Text Messaging

Staff Signature Date

Border Area Mental Health Services, Inc.
dba Southwest Counseling Center, Inc.

APPOINTMENT CANCELLATION POLICY

To ensure the effective scheduling and patient flow, Southwest Counseling Center, Inc. (SWCC), dba Border Area Mental health Services Inc. (BAMHS), requires a 24-hour cancellation notice for all scheduled appointments. It is important to us that you keep your appointment to better serve you with your mental health needs. As a courtesy, we will text and/or call to remind you of your appointment.

If you cancel or no show for three appointments, your services with our agency will be terminated and you will be referred out to continue your care. It will be your responsibility to establish care at another facility or office.

A charge of $25.00 will be billed directly to you 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 SWCC/BAMHS. We will not bill your insurance company for this charge. It will be your responsibility.

EMERGENCY NUMBERS

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 physician/medical provider is available. All messages are reviewed by the physician/medical provider; however, the call may be returned by a medical assistant or other staff member.

Please be aware that the providers will not leave their scheduled patients to return routine phone calls; these are generally answered after patient care sessions are finished. Every patient is responsible for calling the office during business hours for routine prescriptions refills. Medication refills are not provided on an emergency basis. The office requires up to 5 business days to process a refill request.

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

911

For mental health crisis intervention assistance after normal business hours, please call the agency phone number or:

New Mexico Crisis Line 855-662-7474

National Suicide Prevention 800-273-8255

Domestic Violence Hotline 800-799-7233

BORDER AREA MENTAL HEALTH SERVICES, INC.
dba SOUTHWEST COUNSELING CENTER, INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE READ AND REVIEW THIS FORM CAREFULLY.

Border Area Mental Health Services, Inc.(BAMHS)/Southwest Counseling Center, Inc. (SWCC) uses health information about you for treatment to obtain payment for your treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the property of BAMHS & SWCC.

For Treatment: BAMHS/SWCC may use your health information to provide you with medical treatment or services. For example, information obtained by a health provider, such as a physician, nurse, and/or any other person providing health services to you will be obtained, upon your request, and used to determine what type of treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and not how you respond.

For Payment: BAMHS/SWCC may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payee such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: BAMHS/SWCC may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcome in your case and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments: BAMHS/SWCC may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising: BAMHS/SWCC may use your information to contact you to raise funds for needed and/or improved services not covered under insurance or other health plans.

Group Health Plans: A group health plan, health insurance provider, or HMO with respect to a group health plan may disclose health information to the sponsor of the plan.

Required by Law: BAMHS/SWCC may use and disclose information about you as required by law. For example, BAMHS/SWCC may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability, or for other health oversight activities.

Descendants: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Your health information may be disclosed for cadaveric organ, eye or tissue donation purposes.

Research: BAMHS/SWCC may use your health information for research purposes when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information and has approved the research.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other Uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent BAMHS/SWCC has taken action in the reliance of such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures or your information as provided by CFR 164.522; however, BAMHS is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524;
- Request that your health record be amended as provided in 45 CFR 164.526;
- Request communications of your health information by alternative means or alternative locations; and
- Receive an accounting of disclosures made of your health information as provided by 45 CFR 164.526

COMPLAINTS:

You may complain to BAMHS and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

BAMHS is required by law to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we were unable to agree to the requested restriction on how your information is used or disclosed; and
- Accommodate reasonable requests you may make to communicate health information by alternative means or alternative locations.

BAMHS reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you.

If you have any questions or complaints, please contact: Border Area Mental Health Services, Inc.; Chief Executive Officer; PO Box 1349; Silver City, NM 88062; Phone: (575) 388-4497

BORDER AREA MENTAL HEALTH SERVICES, INC. (BAMHS) dba SOUTHWEST COUNSELING CENTER, INC. (SWCC)

CLIENTS RIGHTS

You have the right to:

- Ask about and be given a copy of your rights and responsibilities
- Receive help in exercising your rights
- Be treated with dignity
- Be alone when you see, talk to, or write to others
- Confidential treatment
- Receive services regardless of race, color, national origin, age, gender, or disability
- Be told about your treatment and its consequences
- Be as free as your plan allows
- A prompt review of your complaints
- Read your records and add information unless therapist/care manager decides it would be harmful to you
- Assistance from the appropriate advocate
- All legal rights
- The right to know the qualifications and experience of the clinician providing services
- The right to participate in the development of your individualized treatment plan
- The right to ask questions about the type of counseling strategies employed
- The right to terminate counseling services at any time
- The right to be referred to alternative services not provided by BAMHS/SWCC
- The right to confidentiality. This means the information shared with the staff is not discussed outside the agency.

Exceptions to the Confidentiality Rule are as follows:

a. If a person is deemed to be dangerous to self or others, the proper authorities must be notified.
b. If it is suspected that the client is a perpetrator of child abuse (sexual, physical, or emotional) or an abuser of an incapacitated adult, the proper authorities must be notified.
c. If it is suspected that the client is a victim of child abuse (sexual, physical, or emotional) or an incapacitated adult is the suspected victim of abuse, the proper authorities must be notified.
d. If court ordered, the agency may notify the referring court about attendance and progress in counseling
e. If the client signs a “Release of Information” form allowing disclosure of information.
f. If mandated by State regulatory agencies audit requirements or insurance providers.
g. If the counselor is a defendant in a civil or criminal action arising from the therapy in which case client confidences may be disclosed in the course of that action under court order.
h. If my file is audited by the funding source that pays for the services I receive.
i. If there is a medical emergency as stated in New Mexico Statute 43-1-19.

Confidentiality of Alcohol and Drug Abuse Client Records

The confidentiality of alcohol and drug abuse client records maintained by BAMHS/SWCC is protected by federal law and regulations. Generally, BAMHS/SWCC cannot:

1. Convey to a person outside the Agency the identity of a client, or
2. Disclose any information identifying a client as receiving alcohol or drug abuse services unless:
    a. The client consents in writing, or
    b. The disclosure is allowed by court order in accordance with Federal Code 42 CFR Part 2, or
    c. The disclosure is made to medical personnel in a medical emergency or to a qualified person for research, audit or program evaluation.