La Mente
BEHAVIORAL HEALTH

6600 Montana Ave., Ste. P · El Paso, Texas 79925
1030 N. Zaragoza Rd., Ste. Y · El Paso, Texas 79907

DEMOGRAPHIC FORM

DATE:____/____/____

If minor, Guardian name: _____

PATIENT NAME: _____

DOB: _____ AGE: _____ SSN: _____-_____-_____ MALE ☐ FEMALE ☐ OTHER ☐

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

PHONE: (___) _____ ALTERNATIVE PHONE#: (____) _____ EMAIL: _____

May we leave you messages on your answering system regarding appointment reminders and/or services that may interest you? YES ☐ NO ☐

MARTIAL STATUS: SINGLE ☐ MARRIED ☐ SEPERATED/DIVORCE ☐ WIDOWED ☐

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ Phone #:(____) _____

REFERRAL SOURCE: _____ PRIMARY PHYSICIAN: _____

PREFERRED PHARMACY: _____ PHARMACY PHONE: (____) _____

Legal Authorized Representative (LAR) is a person authorized by law to act on behalf of an individual which includes, parent, guardian, or manager conservator.

DO YOU HAVE AN ASSIGNED LEGAL AUTHORIZED REPRESENTATIVE (LAR)? YES ☐ NO ☐

NAME: _____ PHONE: (____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE:

INSURANCE NAME: _____ NAME OF INSURED: _____

RELATIONSHIP: _____ DOB: _____ SSN: _____-_____-_____

MEMBER ID: _____ GROUP ID (IF APPLICABLE) _____

AUTHORIZATION NUMBER: _____

SECONDARY INSURANCE:

INSURANCE NAME: _____ NAME OF INSURED: _____

RELATIONSHIP: _____ DOB: _____ SSN: _____-_____-_____

MEMBER ID: _____ GROUP ID (IF APPLICABLE) _____

COPY OF INSURANCE CARD NEEDED

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MEDICAL HISTORY **Date: _____/_____/_____**

Patient Name: _____

DOB: _____/_____/_____

1. Medical History: _____

2. Has patient had any surgeries? What type and dates:

_____

3. Has patient had any psychiatric hospitalizations?, if so, please list dates and name/names of hospital

_____

4. Does patient smoke/vape/dip? How many times a day? _____

5. Does patient have allergies to any medications or food? _____

_____

6. Does patient drink alcohol? If yes, how many drinks per day? _____

7. Does patient have a history substance abuse? _____

8. Has patient had any accidents or injuries that we should be aware of?

_____

9. List any current medications: _____

_____

Patient/Guardian Signature: _____ Date: _____/_____/_____

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COORDINATION OF CARE

Medical Coordination of Care and Release of Health Record:

To coordinate with your Primary Care Physician (PCP) or Healthcare provider, it is necessary for **La Mente Behavioral Health LLC** to request your per permission to discuss any medical history orders, illness or injury, treatment plan, or diagnosis, etc from your current or past with your medical provider.

You have the right to refuse consent. It will not affect your treatment, Medicaid benefits or payment.

Patient Name: _____DOB: _____/_____/_____

Please initial below:

_____ I authorize **La Mente Behavioral Health LLC**, to coordinate and request information such as (check those that apply)

____ Medial History ____ Doctors Orders ____ Diagnosis ____Labs

____ Other _____

From (PCP/Healthcare provider) Name: _____

Address: _____ Phone: _____Fax#: _____

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Secure Fax: (915) 233-3053

Secure Email: info@lamentehealth.com

____I do NOT authorize La Mente Behavioral Health to obtain/coordinate /discuss my past or present medical information with any internal or external providers.

Patient /Guardian Signature: _____ Date: _____/_____/_____

Witness/Staff Name: _____ Signature: _____ Date ___/____/____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

It is required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical and mental health records and other identifiable health information. The HIPPA privacy regulations require, or health care providers and organizations, as well as their business associates, to develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, shared. This applies to all forms of PHI, including paper, oral and electronic, etc. Furthermore, only the minimum health information necessary to conduct business is to be used or shared. The explanation of how **La Mente Behavioral Health LLC** handles your (PHI) is found on the Notice of the Privacy Practices (NPP). Please acknowledge below your receipt and understanding of the NPP:

You have the right to revoke this consent in writing signed by you at any time. Full disclosure will then cease: however, such revocation is not retroactive.

(Please initial below)

_____I acknowledge that I have read and understand the Notice of Privacy Practices, which explain how my protected health information is used and disclosed.

_____I acknowledge that I can receive a copy of the Notice of Or Privacy Practices at any time upon request.

_____I acknowledge that I can access my medical record upon request, with exception to psychotherapy notes, which are separated from medical records.

_____I acknowledge that I can change my mind on how I want La Mente Behavioral Health to use or share my information other than as described here. If I change my mind, I will let La Mente Behavioral Health know in writing.

_____I acknowledge that La Mente Behavioral Health cannot disclose my health information other than what was specified in the notice.

_____I acknowledge that La Mente Behavioral Health reserves the right to change the terms of the notice at any time.

By signing this form, you consent to our use and disclosure of you protected health information (PHI) and potentially anonymous usage I publication. You understand that PHI may be used and disclose for treatment, payment and health care operations. **La Mente Behavioral Health LLC** reserves the right to change the privacy policy as allowed by law.

Print Patient Name: _____ Date: _____/_____/_____

Patient/Guardian Signature: _____ Staff/Witness: _____

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CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommend medical or diagnostic procedure to be used, so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point of your care, no specific treatment plan has been recommended. This consent for is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or medication for any identified conditions.

Patient Name: _____ Date: _____/ _____/_____

The consent will remain in full effect until it is revoked in writing. You have the right to revoke this consent and discontinue services at any time. You have the right to discuss the treatment plan with your physician or provider, regarding the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your physician or provider, we encourage you to ask questions.

This consent provides La Mente Behavioral Health with your permission to perform reasonable and necessary medical examinations, mental health assessments, testing and treatment. By signing below, you are indication that:

(1) You intend that this consent is continuing in nature, even after a specific diagnosis has been made and treatment is recommended.

(2) You consent to treatment at this office, in person or via telehealth, or any other satellite office under common ownership.

(Please Initial)

_____I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist), other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

_____I understand that if additional testing, invasive or interventional procedures are recommended. I will be asked to read and sign additional consent forms prior to the test or procedures recommended.

_____I certify that I have read and fully understand the above statements and consent is fully and voluntarily to its contents.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Printed Name of Patient/Guardian: _____ Relationship: _____

Staff/Witness: _____Date: _____/_____/_____

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PATIENT RIGHTS

Dear Patient,

This is to inform you of your rights and how to access your medical records with La Mente Behavioral Health. This notice contains a patient's rights section describing your rights under the law. You are ascertaining by your signature, that you reviewed our notice before signing this consent.

- You have the right to file a complaint (brochure of clients rights available at front desk)
- You have a right to Individual Responsibilities.
- You have a right to your case, records, upon request.
- You have a right to be notified an informed when changes are made to the program.
- You have a right to be treated with dignity and respect.
- You and your family have a right to be provided with information/education in the language of your choice.
- You have a right to appoint a relative or surrogate when you are incapacitated to request an advance directive. We will comply.
- You have the right to restrict how we disclose your protected health information. We are not required to agree with this restriction, but we will honor it.

I understand that I can request a review of services if I am dissatisfied, have any concerns, or found ineligible for services.

The process to do that has been explained to me as follows:

1. To request a review of my concerns or the decision to modify services, I can contact the Clients Rights Advocate of any other La Mente Behavioral Health staff verbally, or in writing.
2. I can grant consent to which I choose to be with me during a review or inquire about changes.
3. I will have the opportunity to express my concerns in person, in writing, by phone or have a representative speak with the reviewers on my behalf.

Natasha Rivera, Client Right Advocate
6600 Montana Ave. Ste. P
El Paso, Texas 79903

Department of Aging and Disability Services
(DADS) Consumer Rights & Services
1-800-458-9858

For Abuse, Neglect or Exploitation
Contact: Department of Family and Protective Services

Disability Rights Texas
1-800-948-1824 (MHID)

Patient/Guardian Signature: _____ Date: _____

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NO SHOW/ CANCELLATION POLICY

La Mente Behavioral Health schedules appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it's very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, La Mente Behavioral Health sends text message reminders and calls one day prior to appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50 "no-show" service charge to your account.

This "no-show charge" is not reimbursable by your insurance company.

You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you. By your signature below, you acknowledge you understand the "no-show" policy of La Mente Behavioral Health.

Thank you for your understanding.

La Mente Behavioral Health LLC

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

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PATIENT AGREEMENT FORM

Thank you for selecting La Mente Behavioral Health. In order to facilitate your treatment, we ask that you read and sign this agreement and authorization.

- Should you need to cancel your appointment, we request a 24 hr. notice.
- You agree to be responsible for payment of all fees in full at the time of your appointment, including co-payments.

FINANCIAL AGREEMENT

Your insurance company requires a co-payment/coinsurance to be paid when you seek certain medical services. In turn, we are contractually obligated to collect any deductible, co-payment, or coinsurance from our patients.

I acknowledge that my insurance company and I have an agreement and I am responsible for the payment of any co-payment, coinsurance, or deductible for services provided to me, or my dependent.
I promise and attest that I will pay the required deductible, co-payment, or coinsurance to La Mente Behavioral Health within thirty (30) business days from receiving a bill. Patient statements are mailed when explanation of benefits are received from your insurance company.

_____ _____

Signature of Patient Date

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PATIENT CONSENT REGARDING LABORATORY TESTING

I, _____, acknowledge and consent to the following:

1. In connection with my treatment with La Mente Behavioral Health, LLC, La Mente providers may order laboratory tests, which require bodily fluids, such as blood or urine, to be drawn or provided. Qualified La Mente staff members may draw or collect samples of such bodily fluids.

2. The actual laboratory tests on the samples provided are performed by Quest Diagnostics. To facilitate the testing, La Mente needs to provide the samples, as well as provide identifying patient information about me, to Quest Diagnostics.

3. La Mente does not bill for any laboratory services. Quest Diagnostics bills for its services, i.e., laboratory testing. Quest Diagnostics also maintains the results of the laboratory testing and shares those results with La Mente once they are available.

4. By my signature below, I consent to La Mente's drawing or collection of bodily fluid samples as ordered by my provider, consent to La Mente's release of those samples and identifying patient information to Quest Diagnostics which performs the laboratory testing, consent to being billed by Quest Diagnostics for such testing, and consent to Quest Diagnostics' release of testing results to La Mente in connection with the treatment I receive at La Mente.

Patient Name/Print name: _____

Patient/Guardian Signature: _____

Date: _____/_____/_____

Authorization for Disclosure, Use, or Receipt of Protected Health Information

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Phone: 915-201-0199
Fax: 915-233-3053

You have the right to refuse to sign this authorization. La Mente Behavioral Health will not withhold treatment, Medicaid benefits, or payment processing if you refuse to sign this authorization. You will receive a copy of this signed authorization.

Individual: _____ DOB: _____ SS#: _____

Dates of Service: _____

I authorize the designated staff at **La Mente Behavioral Health** to disclose/use/receive the following protected health information* about me:

___ Psychiatric Evaluation	___ Laboratory Reports	___ Treatment Plans	___ Psychotherapy Notes
___ Physical Exam	___ Referral Instructions	___ Physician's Progress	___ Social Service Notes
___ Discharge Summary	___ Physician's Orders	___ Nursing Notes	___ Other (Specify) _____
___ Copy ENTIRE record	___ Discharge Instructions	___ Med Reconciliation	___ Other (Specify) _____

The facility's designated staff may disclose to/receive from: _____
(Name of person, organization, or facility)
Address: _____
_____
Phone: _____ Fax #: _____

The disclosure is for the following purpose(s):

___ To coordinate my discharge planning/placement
___ At my request
___ To discuss with my family the care and treatment I receive
___ Other (specify) _____
___ To assist in my educational placement
___ To assist in additional funding.

*By signature below, I hereby authorize La Mente Behavioral Health to Release an to Obtain information with respect to any physical, psychiatric or drug/alcohol related condition, including treatment of Acquired Immune Deficiency Syndrome (AIDS) and/or HIV testing obtained during the course of diagnosis and/or treatment to/from the individual(s) or healthcare provider(s) indicated below. The type of information authorized for disclosure includes, but may be limited to, that which is indicated below.

Note: If you are authorizing disclosure of information, then, except for information related to alcohol and drug abuse treatment, the potential exists for the information described in this authorization to be re-disclosed by the recipient. If the information is re-disclosed, then is it no longer protected by medical privacy law.

Note: If you are singing as a parent/guardian/managing conservator of a minor or as a guardian of the person of an adult, the information, disclosed/used/received may contain references about you and your family.

You have the right to revoke this authorization. To revoke this authorization, you must deliver a written statement, signed by you, to the organization of family where you gave your authorization (identified above), which provides the date and purpose of this authorization and your intent to revoke it. Your revocation will be effective the date it is received by the organization/facility, except to the extent that the organization/facility has already relied upon your authorization to use or disclose your health information as described in the Notice of Privacy Practices.

An Authorization remains valid unless effectively revoked in writing by the individual.

_____ _____
Patient/Guardian Signature Date

_____ _____ _____
Representative's Signature, if any Representative's Relationship to Individual Date

As of the date specified, I wish to revoke this authorization _____ _____
Individual's Signature Date

A photocopy or facsimile transmission is a valid as the original

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**
☐	☐	☐	☐

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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

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

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

HealthTech USA

Patient Assessment Questionnaire

This baseline questionnaire is intended to help your physician learn about you and your neurological medical history to diagnose, decide about specific treatment, and plan your care.

Patient name (print): _____ DOB: _____

1. Do you have any history of seizures or suspected seizures in the past? Yes ☐ No ☐
2. Have you ever passed out in the past? Yes ☐ No ☐
3. Do you have any neurological symptoms without a definite root cause? Yes ☐ No ☐
4. Have you ever had a stroke in the past? Yes ☐ No ☐
5. Have you ever been diagnosed with abnormal heart rhythm that causes you to feel like you are going to pass out or passed out? Yes ☐ No ☐
6. Do you get tired or drowsy during the day? Yes ☐ No ☐
7. Do you have any tremors anywhere in your body? Yes ☐ No ☐
8. Do you have recurrent muscle cramps? Yes ☐ No ☐
9. Do you have any muscle twitches in your body? Yes ☐ No ☐
10. Do you have sleep apnea? Yes ☐ No ☐
11. Do you ever feel disoriented even for a second? Yes ☐ No ☐
12. Do you ever feel restless and agitated? Yes ☐ No ☐

Patient Signature: _____Date: _____