Midland Mental Health Services
4220 Terrace Avenue Suite B
Huntington, WV 25705
Phone: (304)955-6300
Fax: (304)733-5903

MIDLAND MENTAL HEALTH SERVICES NEW PATIENT PACKET

Patient Name_____

Address_____City_____State_____Zip_____

DOB_____SS#_____Home Phone_____Cell Phone _____

Occupation _____Work Phone _____

Married_____Divorced_____Single_____Widowed_____Minor_____

Preferred Pharmacy _____Location_____

Guardian contact (if under 18)_____Phone _____

IN CASE OF EMERGENCY

Name_____

Relationship to Patient _____

Home Phone_____Cell Phone _____

INSURANCE INFORMATION

Primary Insurance_____Policy # _____

Secondary Insurance_____Policy # _____

Tertiary Insurance _____Policy # _____

Please initial each of the following and sign:

I hereby authorize the release of any medical information necessary to process any insurance claims and/or payments. _____

I authorize assignment of my benefits so that payment of any and all insurance benefits be made on my behalf directly to my provider's office. _____

_____

Signature of Patient (Parent/Guardian if a minor) Date

_____

Signature of Patient (12 years old or older) Date

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Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of these questions required only a check, so it will go quickly. You may need to ask family members about our family history. Thank you!

Name_____Date_____

Date of Birth _____Primary Care Provider_____

Do you give permission for ongoing regular updates to be provided to your primary care providers? _____

Current Therapist/Counselor _____Therapist/Counselor Phone _____

What are the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (check once for any symptom present, twice for major symptoms)

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep pattern disturbance
- ☐ Loss of interest
- ☐ Concentration/forgetfulness
- ☐ Change in appetite
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Decreased libido
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increase risky behavior
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Excessive worry
- ☐ Anxiety attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ _____
- ☐ _____

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Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ◯Yes ◯No
If YES, please answer the following. If NO, please skip to the next sections.
Do you currently feel that you don't want to live? ◯Yes ◯No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
One a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Past Medical History:

Allergies_____ Current weight_____ Height _____

List ALL current prescription medications and how often you take them (if non, write none) or have list available for appointment.

Medication Total Daily Dosage Estimated Start Date

_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, non-psychiatric hospitalizations, or surgeries: _____

_____

Have you ever had an EKG? ◯Yes ◯No; If yes when? _____

Was the EKG ◯Normal ◯Abnormal or ◯Unknown

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Past Psychiatric History:

Outpatient Treatment ◯Yes ◯No; If yes, describe when, by whom, and nature of treatment

Reason **Date Hospitalized** **Where**

_____

_____

_____

Psychiatric Hospitalization: ◯Yes ◯No; If yes, describe for what reason, when and where.

Reason **Date Hospitalized** **Where**

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all of the details, just write in what you do remember).

Dates **Dosage** **Response/Side-Effects**

Antidepressants

Vilazodone (Viibryd) _____
Desvenlafaxine (Pristiq) _____
Vortioxetine (Trintellix)_____
Prozac (Fluoxetine) _____
Zoloft (Sertraline) _____
Luvox (Fluvoxamine)_____
Paxil (Paroxetine) _____
Celexa (citalopram)_____
Lexapro (Escitalopram) _____
Effexor (Venlafaxine) _____
Cymbalta (Duloxetine) _____
Wellbutrin (Bupropion)_____
Remeron (Mirtazapine)_____
Anafranil (Clomipramine) _____
Elavil (Amitriptyline) _____
Other_____

Mood Stabilizers

Tegretol (Carbamazepine) _____
Lithium _____
Depakote (Valproate) _____
Lamictal (Lamotrigine) _____
Topamax (Topiramate) _____
Other_____

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Past Psychiatric Medication (continued)

Antipsychotics/Mood Stabilizers	**Dates**	**Dosage**	**Response/Side-Effects**
Rexulti (Brexpiprazole)			
Latuda (Lurasidone)			
Vraylar (Cariprazine)			
Seroquel (Quetiapine)			
Zyprexa (Olanzapine)			
Geodon (Ziprasidone)			
Abilify (Aripiprazole)			
Clozaril (Clozapine)			
Haldol (Haloperidol)			
Risperdal (Risperidone)			
Other			
Sedative/Hypnotics			
Ambien (Zolpidem)			
Sonata (Zaleplon)			
Rozerem (Ramelteon)			
Restoril (Temazepam)			
Desyrel (Trazodone)			
Other			
ADHD Medications			
Adderall (Amphetamine)			
Concerta (Methylphenidate)			
Ritalin (Methylphenidate)			
Strattera (Atomoxetine)			
Focalin (Dexmethylphenidate)			
Vyvanse (Lisdexamfetamine)			
Other			
Antianxiety Medications			
Xanax (Alprazolam)			
Ativan (Lorazepam)			
Klonopin (Clonazepam)			
Valium (Diazepam)			
Tranxene (Clorazepate)			
Buspar (Buspirone)			
Other			

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Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Biopolar disorder	◯Yes ◯No	Schizophrenia	◯Yes ◯No
Depression	◯Yes ◯No	Post-traumatic Stress	◯Yes ◯No
Anxiety	◯Yes ◯No	Alcohol Abuse	◯Yes ◯No
Anger	◯Yes ◯No	Other substance abuse	◯Yes ◯No
Suicide	◯Yes ◯No	Violence	◯Yes ◯No

If yes, who had each problem?_____

_____

_____

Has any family member been treated with a psychiatric medication? ◯Yes ◯No; If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

_____

Substance Abuse:

Have you ever been treated for alcohol or drug use or abuse? ◯Yes ◯No

If yes, for which substance? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol?_____

What is the lease number of drinks you will drink in one day? _____

What is the most number of drinks you will drink in one day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?

_____

Have you ever felt you ought to cut down on your drinking or drug use? ◯Yes ◯No

Have people annoyed you by criticizing your drinking or drug use? ◯Yes ◯No

Have you ever felt bad or guilty about your drinking or drug use? ◯Yes ◯No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of hangover? ◯Yes ◯No

Do you think you may have a problem with alcohol or drug use? ◯Yes ◯No

Have you used any street drugs in the past 3 months? ◯Yes ◯No

If yes, which ones? _____

Have you ever abused prescription medications? ◯Yes ◯No

If yes, which ones and for how long? _____

_____

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Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	◯	◯	_____
Cocaine	◯	◯	_____
Stimulants (pills)	◯	◯	_____
Heroin	◯	◯	_____
LSD or Hallucinogens	◯	◯	_____
Marijuana	◯	◯	_____
Pain killers (not as prescribed)	◯	◯	_____
Methadone	◯	◯	_____
Tranquilizers/sleeping pills	◯	◯	_____
Alcohol	◯	◯	_____
Ecstasy	◯	◯	_____
Other	◯	◯	_____

How many caffeinated beverages do you drink a day? Coffee _____ Soda _____ Tea _____

Tobacco History: **Smoker?** ◯ Yes ◯ No **Smokeless Tobacco?** ◯ Yes ◯ No
Have you ever smoked cigarettes? ◯ Yes ◯ No Currently? ◯ Yes ◯ No
How many packs per day on average? _____ How many years? _____
In the past? ◯ Yes ◯ No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? ◯ Yes ◯ No In the past? ◯ Yes ◯ No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:
Were you adopted? ◯ Yes ◯ No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents divorce? ◯ Yes ◯ No If so, how old were you when they divorced? _____
If your parents are divorced, who did you live with? _____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:
Did you have a history of being abused emotionally, sexually, physically, or by neglect? ◯ Yes ◯ No
Please describe when and by whom: _____
Educational History:

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Highest Grade Completed?_____ Where? _____
Did you attend college? _____ Where? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( )Working ( )Student ( )Unemployed ( )Disabled ( )Retired
How long in present position? _____
What is/was your occupation? _____
Where did you work? _____
Have you ever served in the miliary? _____ If so, what branch and when? _____
Honorable discharge? ( )Yes ( )No Other type of discharge? _____

Relationship History and Current Family:
Are you currently: ( )Married ( )Partnered ( )Divorced ( )Single ( )Widowed
How long? _____
If not married, are you currently in a relationship? ( )Yes ( )No If yes, how long?_____
Are you sexually active? ( )Yes ( )No
How would you identify your sexual orientation?
( )Straight/Heterosexual ( )Lesbian/Gay/Homosexual ( )Bisexual ( )Transexual
( )Unsure/Questioning ( )Asexual ( )Other ( )Prefer not to answer
What is your spouse or significant other's occupation?_____
Describe your relationship with your spouse or significant other: _____
_____
Have you had any prior marriages? ( )Yes ( )No If so, how many? _____
How long? _____
Do you have children? ( )Yes ( )No If yes, ages and gender: _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems?_____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( )Yes ( )No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( )more helpful ( )stressful

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Is there anything else that you would like us to know?

Signature: _____ Date: _____

Guardian Signature (if under age 18):_____ Date: _____

Emergency Contact: _____Telephone #:_____

For Office Use Only:

Reviewed by:_____ Date: _____

Reviewed by:_____ Date: _____

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CONSENT / PAYMENT AGREEMNT / RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

Patient Name _____

I hereby consent to examination and/or treatment as recommended by the professional staff of the office_____(initials)

I accept responsibility for payment for all charges and fees for professional services on the above-named patient. I understand that non-payment of my account balance may result in the use of collection/legal action in an attempt for this office to obtain payment for services rendered. I understand that any non-payment may result in provider termination of services with me. Termination of services may also occur if it is determined that the client is uncooperative with treatment, fails to keep scheduled appointments, abuse of medications, failed drug screenings, and leaving inpatient treatment against medical advice, etc._____(initials)

I authorize any insurance benefits that are reimbursable for services be paid directly to this office. I consent to the release and disclosure of all or any part of my medical records to any applicable professional or private review organization and to my insurance company. This office will bill my insurance carrier on my behalf for charge incurred; however, I am responsible for the full amount of my account (with the exception of certain government insurance plans). _____(initials)

I understand that an automated reminder system may be used as reminder for the next appointment. This is strictly a courtesy and, in the event, I do not receive a reminder, it does not relieve me of keeping my appointment or in giving at least 24 hours' notice of cancellation. Failure to give the required notice may result in charges for non-cancellation of appointment time._____(initials)

I received a copy of this office's Notice of Privacy Practices._____(initials)

_____

Signature of Patient (12 years or older – patient must sign) Date

_____

Signature of Parent or Guardian Date

_____

Signature of Parent of Guardian Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REFVIEW IT CAREFULLY.

I. Who We Are

This notice describes the privacy practices of MIDLAND PSYCHOLOGICAL SERVICES. It applies to the health services you receive at our facility. **We share your information among ourselves to carry out our treatment, payment, and health care operations.**

II. Our Privacy Obligations

The law requires us to maintain the privacy of certain health information called **"Protected Health Information" ("PHI").** Protected Health Information is the information that you provide us or that we create or receive about your health care. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of the Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice.

III. Ways We Can Use and Share Your PHI Without Your Written Permission (Authorization)

In many situations, we can use and share your PHI for activities that are common in many hospitals and clinics. In certain other situations, which we will describe in Section IV below, we must have your written permission (authorization) to use and/or share Your PHI. We do not need any type of permission from you for the following uses and disclosures:

A. Uses and Disclosures of Treatment, Payment, and Health Care Operations. We may use and share your PHI to Provide "Treatment," obtain "Payment" for your Treatment, and Perform our "Health Care Operations." These three terms are defined as:

- **Treatment.** We use and share your PHI to provide care and other services to you – for example, to diagnose and treat your illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

- **Payment.** We may use and share y our PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your health care ("**Your Payer"**) and to confirm that Your Payor will pay for health care. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent.

- **Health Care Operations.** We may use and share your PHI for our health care operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use your PHI to review the quality and skill of our physicians, nurses, and other health care providers. In addition, we may share PHI with certain others who help us with our activities, including those we hire to perform services.

B. Your Other Health Care Providers. We may also share PH with your doctor and other health care providers when they need to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.

C. Disclosure to Relatives, Close Friends, and Your Other Caregivers. We may share your PHI with your family member/relative, a close friend, or another person who you identify if we (1) first provide you with the change to object to the disclosure and you do not object; (2) infer that you do not object to the disclosure; or (3) obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgement to decide that sharing your PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your locations and general condition.

D. Public Health Activities. We are required or are permitted by low to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

1. To report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;

2. To report abuse and neglect to Human Services, or other government authorities, including social service or protective services agency, that are permitted to receive the reports;

3. To report information about products and services to the U.S. Food and Drug Administration;

4. To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;

5. To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and

6. To prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

G. Health Oversight Activities. We may share your PHI with a health oversight agency that overseas the health care system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

H. Judicial and Administrative Proceedings. We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

I. Law Enforcement Purposes. We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or subpoena.

J. Decedents. We may share PHI with a coroner or medical examiner as authorized by law.

K. Organ and Tissue Procurement. We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

L. Research. We may use or share your PHI with the group that oversees our research, the Institutional Review

Board/Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to being the research process.

M. Workers' Compensation. We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

N. As Required By Law. We may use and share your PHI when required to do so by any other law not already referred to above.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION (AUTHORIZATION)

A. Use or Disclosure with Your Permission (Authorization). For any purpose other than the ones described above in Section III, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

B. Marketing. We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials. However, we may communicate with you about products or services related to your Treatment, cause management, or care coordination, or alternative treatments, therapies, health care providers, or care settings without your permission. For example, we may not sell your PHI without your written authorization.

C. Uses and Disclosures of Your Highly Confidential Information. Federal and state law requires special privacy protection for certain highly confidential information about you ("Highly Confidential Information"), including any portion of your PHI that is: (1) kept in psychotherapy notes; (2) about mental health and development disabilities services; (3) about alcohol and drug abuse prevention, Treatment and referral; (4) about HIV/AIDS testing, diagnosis or Treatment; (5) about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with disability; (9) about sexual assault; or (10 Invitro Fertilization (IVF). Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact your HIPAA Program Office. You may also file written complaints with the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services. When you ask, the HIPAA Program Office will provide you with the correct address for the OCR. We will not take any action against you if you file a complaint with us or with the OCR.

B. Right to Receive Confidential Communications. You may ask us to send papers that contain your PHI to a different location than the address that you gave us, or in a special way. You will need to ask us in writing. We will try to grand your request if we feel it is reasonable. For example, you may ask us to send a copy of your medical records to a different address than your home address.

C. Right to Revoke Your Written Permission (Authorization). You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the HIPAA Program Office at the address below. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file, billing

records, and other records used to make decisions about your Treatment and payment. If you want to access your records, you may obtain a record request form from us. If you request copies, we will charge you a search fee and per page copied fee. We will also charge you for postage costs, if you requested that we mail the copies to you.

E. Right to Amend Your Records. You have the right to request that we amend PHI maintained in medical record files, billing records, and other records used to make decisions about your Treatment and payment for your Treatment any payment for your Treatment. We will comply with your request unless we believe that the information that would be amended is correct and complete or that other circumstances apply.

F. Right to Receive an Accounting of Disclosures. You may ask for accounting of certain disclosures of your PHI made by us.

H. Right to Receive Paper Copy of this Notice. If you ask, you may obtain a paper copy of this Notice, even if you have agreed to receive the notice electronically.

IV. Effective Date and Duration of This Notice

A. Right to Change Terms of this Notice. You may change the terms of this Notice at any time. If we change this Notice we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice.

Complaints about your privacy rights or how this practice has handled your health information should be directed to this office. If you are not satisfied with the manner in which we handle your complaint you may submit a formal complaint to DHHS, Office of Civil Rights, 200 Independence Avenue S.W., Room 509F HHH Building, Washington, DC 20201.

B. Effective Date. This Notice if effective as of _____.

I HAVE READ THE Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this notice.

_____

Patient's Name (Please Print) Date

_____

Patient's Signature

_____

Witness by (Office Staff) Date

COORDINATION OF CARE CONSENT

Midland Mental Health Services
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Communication between Midland Psychological Services providers and your primary care provider (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the provider's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

MIDLAND MENTAL HEALTH SERVICES is authorized to release protected health information related to the

evaluation and treatment of _____
(Patient Name) (Date of Birth – MM/DD/YYY)

PCP Name: _____ PCP Phone: _____

PCP Address: _____
(Street) (City) (State) (Zip)

Other BH Provider Name: _____ BH Provider Phone: _____

BH Provider Address: _____
(Street) (City) (State) (Zip)

Other Name:_____ Other Phone: _____

Other Address: _____
(Street) (City) (State) (Zip)

_____I do not have a Primary Care Provider (PCP).
_____I hereby refuse to give authorization for any release of information.

_____
(Signature of Patient, Parent, Guardian, or Authorized Representative) Date

If signed by a guardian or authorized representative, please provide legal documentation that provides such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

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Scheduling/Cancellation Policy

It is Midland Psychological Services policy that cancellation of appointments be made 24 hours prior to appointment date to allow our office to fill those time slots.

If there are two or more missed appointments without proper notification, this could result in discharge from the practice. If this occurs it will be addressed on an individual basis.

Scheduling multiple appointments in advance will no longer be allowed if an appointment is missed without proper notification and this will result in cancellation of all appointments that were scheduled in advance with **ALL** providers.

_____

Signature of responsible party Date

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Fax: (304)733-5903

Medication Management Drug Screening Agreement

At Midland Psychological Services it is our duty to make sure we are providing a safe plan of care for all of our patients. In regard to the practice, we have made Drug Screening a mandatory policy at this facility. All New Patients may be required to have a baseline screen on first visit.

Anyone who is prescribed controlled substances may be screened a minimum of every 90 days. Anyone prescribed non-controlled medications may be screened a minimum of 2 screens per year. If the provider and/or lab technician feel a screen is necessary based on medication changes or previous screen results, then an additional test may be requested. It is policy that you must call 24 hours in advance if you need to cancel or reschedule your appointment. Drug Screening and keeping appointments are part of compliance. Multiple failed attempts are considered non-compliant and can result in termination from the practice.

Integra Labs is the lab that will be used per Drug Screening, therefore if insurance is not willing to pay/if you have not reached your deductible, etc., then our Lab Technician will help resolve the issue and find a solution based on each patient's scenario.

If Drug Screens are Failed

1. **First Offense:** If a drug screen is failed you will be called, and you will be asked to repeat the screen. Upon being asked to repeat the screen you have 3 days to come into the facility and you are required to bring in medications prescribed by your provider for a pill count. Both Urine and Oral Swab will be completed and if the Lab Technician feels necessary a blood test will also be performed. You will also be scheduled for a monthly appointment for 3 (three) consecutive months. If you fail to show for a random drug screen, this is considered a **Second Offense**, and your provider will be notified immediately!

2. **Second Offense:** If who screens have been failed, any/all controlled medications will be tapered and weaned down. You will be scheduled monthly appointments without any controlled medications for 6 (six) consecutive months and will report for Random Drug Screens. When you have had 6 (six) months of non-failed screens the provider will use compliant history in consideration to prescribing controlled medications again.

3. **Third Offense:** If you have had a history of non-compliance, the third offense will result in automatic termination. The office will provide a list of new facilities and will send in a 3 (three) month supply of transition scripts for Non-Controlled Medications.

IMPORTANT: If at any given time the provider feels they can not meet a Patient's needs and/or feels the patient is a liability, then termination can result from any offense, including first time New Patients. By signing below, you agree that you have read and agree to follow the above terms.

_____ _____

Printed Name/Date | Provider Signature/Date

_____ _____

Patient Signature | Lab Technician Signature/Date