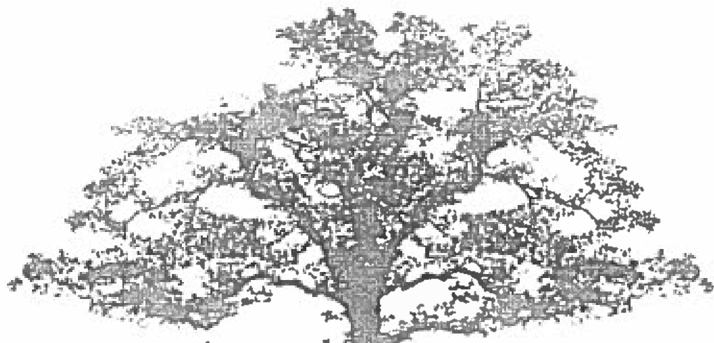

WINDWOOD

FAMILY SERVICES

Registration Packet

Registration Sheet

Date:____________________________

Patient Name: ____
Last First M.I.

Date of Birth: ______-_______-________ Age: _______

Address: ____

City: ___________________________________ State: ______________ Zip: _________

Home Phone :(____) _____-_________ can a message be left at this number? ___yes ___no

Work Phone :(____) _____-__________ can a message be left at this number? ___yes ___no

Ext.: _________

Mobile Phone :(____)_____-_________ can a message be left at this number? ___yes ___no

Pager :(____) _____-_________ E-mail Address______________________________________

How do you prefer to be contacted? ____

Referred by:____

In Case of Emergency, Contact:

Name:__________________________________ Relationship:________________________

Phone:________________________________

Medical History Self Report

Patient's Name: ______________________ Date of Birth: ______________

Allergies to Food, Medication, Other: ______________________

Current Family Physician: ______________________ Date of Last Physical Exam: ______________

Are there currently or have there previously been problems with any of the following?

	Yes	No
Skin problems	☐	☐
Wounds not healing/easy bruising	☐	☐
Glaucoma/Vision	☐	☐
Hearing	☐	☐
Headaches	☐	☐
Head injuries	☐	☐
Black outs/Fainting	☐	☐
Numbness/Tingling	☐	☐
Thyroid problems	☐	☐
Blood sugar	☐	☐
Sickle cell	☐	☐
HIV/AIDS	☐	☐
Fatigue	☐	☐
Anemia/Low blood count	☐	☐
Breathing/Shortness of breath	☐	☐
Fever	☐	☐
Cancer	☐	☐
Excessive movement during sleep	☐	☐
Snoring	☐	☐

	Yes	No
Eating	☐	☐
Alcohol	☐	☐
Street drugs	☐	☐
High blood pressure	☐	☐
Heart disease/Chest pain	☐	☐
Heartbeat irregularities	☐	☐
Rheumatic fever	☐	☐
Nausea/Vomiting	☐	☐
Ulcers	☐	☐
Liver disease or jaundice	☐	☐
Kidney/Bladder problems	☐	☐
Pregnancy (If pregnant, due date ______)	☐	☐
Sexual function		
Pain	☐	☐
Daytime sleepiness	☐	☐
Sleeping too little	☐	☐
Lead/Chemical exposure	☐	☐
Seizures	☐	☐
Change in Weight	☐	☐

Please describe: ______________________

____

Have any family members had any of the following?

	Yes	No	Who
Depression	☐	☐	______
Bipolar Disorder	☐	☐	______
Suicide	☐	☐	______
Schizophrenia	☐	☐	______
Eating Disorder	☐	☐	______
Anxiety Disorder	☐	☐	______
Alcohol/Drug Problems	☐	☐	______
ADHD	☐	☐	______
Thyroid problems	☐	☐	______
Asthma	☐	☐	______
Diabetes	☐	☐	______
Stroke	☐	☐	______
Dementia/Senility	☐	☐	______
Stomach Problems	☐	☐	______
Seizures (what kind	☐	☐	______
Heart Problems	☐	☐	______
Cancer (what kind)	☐	☐	______
High blood pressure	☐	☐	______
Abnormal heart rhythm	☐	☐	______
Sudden cardiac death	☐	☐	______
Tics	☐	☐	______

Have there been hospitalizations for any medical reasons such as illness, accidents, operations, or tests?

Reason for Hospitalization	Date	How Long?

Current Medications (including any over the counter or herbal preparations):

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Other Psychiatric medications which have been taken in the past:

Name of Medication	Dosage	For what reason?	How Long?	Side effects (if any)

Psychiatric care in the past? (Such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

For what reason?	When?	By Whom?	Type of Treatment	Were you hospitalized?

Currently using caffeine? ☐ Yes ☐ No If yes, how much, how often ____________________

Currently using cigarettes? ☐ Yes ☐ No If yes, how much, how often ____________________

Currently using alcohol? ☐ Yes ☐ No If yes, how much, how often ____________________

____

Signature Date

CONFIDENTIALITY STATEMENT

Some important issues regarding confidentiality need to be understood as we begin our work together. Please review this material carefully so that we may discuss any questions or concerns.

In general, law protects the confidentiality of all communications between a patient and treatment provider. I can only release information about our work to others with your written permission. There are a few exceptions, however.

In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. My testimony may also be ordered in other cases including legal proceedings relating to psychiatric hospitalization, malpractice and disciplinary proceedings, court-ordered psychological evaluations, and certain legal cases following the death of a client.

In addition, there are some circumstances when I am required to breach confidentiality without a patient's permission. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgment, I believe that a patient is threatening serious harm to another, I am required to take protective action, which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm himself or herself, I may be required to seek hospitalization.

The clear intent of these requirements is that a treatment provider has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in my practice.

There are several other matters concerning confidentiality:

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee.

3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, I will provide you with a copy of any report to submit.

4. If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment. Your parents may also request a copy of your record from me.

5. Under current South Carolina law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

6. At times, I will be using a cellular phone to contact you or return your calls. Please be aware that I will not notify you when I am using such a device so if the information you are discussing requires a more secure level of confidentiality, please let me know so I can arrange to contact you in another way.

7. I routinely use a fax machine in communication with other agencies. I will only release information that you have authorized me to release and do send these with a cover sheet that includes a confidentiality statement but this does not insure that the fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand carry documents to agencies if you wish. I will also mail documents on special request.

8. I will reply to email messages sent to me and I will make effort to limit the type of information discussed in these messages but again it is important to stress that email is not a confidential mode of communication and should not be utilized if you require a higher degree of security.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable.

I have read the above; fully understand the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

______________________________ __________________

Signature Date

Informed Consent for Out-Patient Services

Rights of Individuals, Children and their Families

1. To be served under humane conditions with respect for dignity and privacy.
2. To receive treatment services that promote their growth and development.
3. To have services delivered in a culturally responsive manner.
4. To receive services in the least restrictive and most appropriate setting.
5. To receive information regarding all Windwood Family Services policies and procedures regarding interventions and the use of behavior management techniques, including crisis prevention intervention techniques.
6. To be served with respect for confidentiality.
7. To be involved in the assessment, individual care planning, and discharge transition from Windwood Family Services.
8. To have the ability to file complaints or grievances.
9. To have all aspects of the array of therapy and intervention services explained to them in regard to the likelihood of the success of the intervention, and the potential benefits, risks, and side effects if a proposed therapy or intervention is used.
10. To be informed of the potential risks and benefits if a specific intervention is not sued, including any service consequences

Family members, legal guardians, and other referring personnel also have the right to be notified following a suicide attempt, medical emergencies, and for a change of prescribed medications. Family members/legal guardians will be informed through written correspondence of any scheduled meetings regarding their child's individualized care services.

____ ________________

Client (age 18 and up) OR Parent/Legal Guardian Date

____ ________________

Windwood Family Services Representative Signature Date

Consent for Treatment

Participation in any treatment program provided by Windwood Family Services is given freely and willingly by the client (age 18 and over) or parent/legal guardian (minor).

Permission is further given for ____

Name of Client Date of Birth

- To participate in any and all treatment interventions utilized by my (or my child's) therapist(s). Prior to beginning treatment, interventions to be used will be explained to me.
- We/I agree to allow my (or my child) to participate in all phases of the treatment programs at Windwood Family Services, knowing we/I may request a review of services at any time I desire.
- We/I consent to give Windwood Family Services and its professional staff the right to provide therapy and therapeutic interactions that will assist me (or my child) in solving identified problems.
- We/I consent to permit to receive (or permit my child to receive) individual and group therapy, ongoing assessments and evaluations, psychiatric and psychological evaluations when deemed necessary or advisable.
- We/I agree to attend family therapy sessions and parent/child groups as outlined in the Individual Plan of Care.
- We/I acknowledge that information concerning me or my child may be stored and/or coded on a computer. It will be held according to HIPAA statutes and state and federal laws of confidentiality. All records will be kept in locked containers and maintained for lengths of time according to state and federal laws.
- We/I acknowledge that Windwood Family Services does not discriminate against racial, religious, cultural, or ethnic backgrounds of its applicants or their families.

____ ____________________

Client (age 18 and up) OR Parent/Legal Guardian Date

____ ____________________

Windwood Family Services Representative Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT Alicia Hinson, Our Deputy Director, at 843-884-5342x222

Protected Health Information (PHI) is demographic and individually identifiable health information that will or may identify the client and relates to the client's past, present, or future physical or mental health or condition and related health care services.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

This Notice of Privacy Practices describes Windwood Farm Home for Children, Inc., DBA Windwood Family Services, practices regarding the use of your Protected Health Information (PHI) and is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

We are required to protect your PHI; to provide you with this Notice; to comply with the Privacy Practices as described in this Notice; and seek your acknowledgment of receipt of this Notice. Services will not be conditioned upon your signed Acknowledgement.

Windwood Farm Home for Children, Inc. reserves the right to change the terms of the Notice of Privacy Practices and to make new Notice provisions effective for the entire PHI that the Agency maintains by first:

- Posting the revised Notice in prominent locations throughout Windwood Farm Home for Children, Inc. service sites;
- Making copies of the revised Notice available upon request; and
- Posting the revised Notice on the Windwood Farm Home for Children, Inc. website **www.windwoodfarm.org**

YOUR PRIVACY RIGHTS REGARDING YOUR HEALTH INFORMATION:

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information.

This means you may inspect and obtain a copy of your PHI that is contained in a "designated record set" for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that Windwood Farm Home for Children, Inc. uses in making decisions about your health care. You may not however, inspect or copy the following records: psychotherapy and psycho-social notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed.

2. You have the right to request a restriction of your health information.

This means you may ask us to restrict or limit the medical information we use and/or disclose for the purposes of treatment, payment, or health care operations. Windwood Farm Home for Children, Inc. is not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use and/or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting your assigned case manager or therapist.

3. You have the right to request to receive confidential communications by alternative means or at alternative locations.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact and, when appropriate, information as to how payment, if any, will be handled. We will not request an explanation from you as the basis for the request. Requests must be made in writing to your assigned case manager or therapist

4. You have the right to request amendments to your health information.

This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with our Privacy Officer and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact your assigned case manager or therapist. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information.

You have the right to request an accounting of certain disclosures of your PHI made by Windwood Farm Home for Children, Inc. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for directory or notification purposes, to family or friends involved in your care, or certain other

disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to your assigned case manager or therapist.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.
You have the right to receive a paper copy of this Notice on the date that you first receive service from us. In emergency situations, we will provide the Notice as soon as possible. You may also obtain a copy of this Notice on our website, www.windwoodfarm.org.

WHAT IF I HAVE A QUESTION OR COMPLAINT?
If you have questions regarding your privacy rights, please contact Windwood Farm Home for Children, Inc. Privacy Officer. If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint; no action will be taken against you or any change made to your treatment.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washinton, DC

Privacy Officer
Windwood Farm Home for Children, Inc.
4857 Windwood Farm Rd.
Awendaw SC 29429

I have been given the opportunity to review the Notice of Privacy Practices for Windwood Farm Home for Children, Inc., DBA Windwood Family Services

________________________________ __________

Client (age 16 and up) Date

________________________________ __________

Parent/Legal Guardian Date

________________________________ __________

Windwood Family Services Representative Date

Office Policies and Procedures

The general policies of the office are explained below. Please take a few minutes to review them and bring up any questions with your therapist.

Contacting Your Therapist

- The phone contact number for your therapist is (843)884-0025.
- There are times when your therapist is with a client, or not able to answer the phone, and you are encouraged to leave a voice mail message with your name, number, time of call, as well as a brief message and the best time to reach you. All messages are treated confidentially, your call will be returned as soon as possible.
- **If you feel that you need immediate assistance please call 911 or go to the nearest emergency room.**
- We do not encourage emailing your therapist. Email can be overlooked or can go into a spam filter, and is not the most confidential form of communication. However, you may email the billing specialist (pentrina.stewart@windwoodfarm.org) if you have questions about insurance remittances.
- Clients are discouraged from contacting their therapist on any form of social media.

Insurance

- Windwood Family Services will bill private insurances for which the therapists are in network. However, it is the ultimate responsibility of the client (or client's parent/guardian(s)) to provide payment for any services not covered by insurance.
- Please respond promptly to invoices and keep up with payments or the therapist may be forced to pause treatment until payment is received in full.
- Clients who have active coverage Medicaid as the primary insurance can not be billed for uncovered services.

Intake and Consent Forms

- For ethical and legal reasons, clients are required to read, complete and sign intake, HIPAA and consent forms and bring these to the initial appointment.
- Please read all forms thoroughly and sign where indicated.
- Please note that the release of client clinical information is strictly governed by Health Insurance Portability and Accountability Act (HIPAA). Under this law, the release of any information cannot be made until a specific authorization to release is signed by the client.

In Session Behavior

- The therapeutic process can sometimes be very difficult, You are encouraged to talk about all of your thoughts and feelings during the therapy session.
- It is ok to express your anger in a therapy session, but loud shouting and throwing things is never appropriate.
- While your privacy is of utmost concern, you should be aware that any incidents of abuse or threats to others must be reported.
- IF you feel that you may harm yourself in anyway, you should discuss this immediately with your therapist. Suicidal threats may result in notifying the patient's emergency contact and other people who can keep you safe. Your safety is our number one concern.
- It is never appropriate to bring any form of weapon into therapy, and clients who bring in a weapon will be asked to leave.

Waiting Room Rules

- **Please do not bring children under 12 to wait while you are in therapy**
- Please accompany children under the age of 12 to the restroom at all times.
- Please do not bring food or beverages to your therapy session
- This is a smoke free office and any kind of smoking, including e-cigarettes, is not allowed.

Windwood Family Service's Cancellation and No Show Policy

For all scheduled appointments, we require a minimum of 24 hour notice to cancel an appointment. Please call the number and speak with the office manager or leave a voicemail 24 hours or more before the scheduled appointment time if you will not be able to keep the appointment. The exceptions to the 24 hour include medical or mental health emergencies.

If you do miss a scheduled appointment without 24 hours notice, we count the appointment as a "no-show". Therapists will close a case and discontinue therapy with any client that has 3 no shows.

For all non-medicaid clients. we charge a $40 fee for any scheduled appointment that the client misses without 24 hour notice. Sessions may be discontinued until the balance is paid.

I have read and understood the cancellation and no-show policy and agree to adhere to the protocol.

(Client or Legal Guardian)Signature　　Name (printed)　　Date

Windwood Family Services Representative Signature　　Date

Release/Request to Obtain Information

This form must be completed in its entirety in order to be considered valid

Resident/Client: ______________________________ Date of Birth: ____________

☐ I authorize Windwood Family Services to disclose/release information to:____________________
(Information released will be information generated only by Windwood Family Services or its contractors)

☐ I authorize Windwood Family Services to obtain information from:

Name of Organization: ____

Street Address:____________________ City:____________ State:______ Zip Code:______

Phone Number:______________ Fax:____________ Email Address:______________

The purpose of the disclosure is ____

The type of information to be disclosed is as follows:

_____ Entire record   _____ Physicians Orders   _____Other (specify) ____________

_____ Court Orders   _____ Consultation reports

_____ School records   _____ Progress Reports – Clinician

For the dates of service: ______________ to ______________

I understand this information may include reference to:

_____ Psychiatric/psychological care   _____ Sexual assault

_____ Drug abuse   _____ Alcohol abuse

I authorize the exchange of this information via (check all preferred methods):__mail__ fax __ e-mail __ other_____

I understand that I will be given a copy of this authorization.

______________________________ ____________ ____________
Signature of Parent/Legal Guardian /DJJ Representative   Relationship   Date

______________________________ ____________
Signature of Windwood Family Services Representative   Date

Unless otherwise revoked or cancelled (see box below), this authorization will expire/end one year from date of signature or upon termination of service.

WITHDRAWAL OF PERMISSION FOR USE AND/OR DISCLOSURE OF INFORMATION

I withdraw my authorization to release information about my child, ______________ to an inquiring agency.

______________________________ ____________
Signature (Parent/Legal Guardian)   Witness

______________________________ ____________
Relationship to Client   Date

All information obtained for purposes of treatment and service while in care at Windwood Family Services is protected from disclosure by federal and state law including, as applicable 45CFR Part 2 (alcohol and drug treatment), and Section44-22-100, Code of Laws of South Carolina

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

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 figety 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	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 ______

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A2663B 10-04-2005

PLEASE PRINT

Patient's Name: (Last Name. First Name. Middle Initial)	Patient's Birthdate: (MM/DD/YY) / / Sex: ☐ M ☐ F
Patient's Address: (No., Street)	Patient's Social Security Number:
City, State, Zip Code:	Telephone: Work ( ) Home ( ) Cell: ( )
Patient Status: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	Is Patient's Condition Related to: a: Employment? Current or Previous Yes ☐ No ☐ b. Auto accident? Yes ☐ No ☐ c. Other accident? Yes ☐ No ☐

Insurance Information:

Insured's Name: (Last Name, First Name. Middle Initial)	Insured's ID Number:
Insured's Address: (No., Street)	Insured's Social Security Number:
City. State. Zip Code:	Insured's Date of Birth: MM/DD/YY:
Employer Name:	Patient Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Address: (No., Street) City, State, Zip Code	Telephone: Work ( ) Home ( ) Cell: ( )
Responsible Party: (If different from Insured)	Relationship to Patient:
Address: City, State, Zip Code:	Telephone: Work ( ) Home ( ) Cell: ( )
Primary Insurance Company: (Name)	**Secondary Insurance Company:** (Name)
Identification Number:	Identification Number:
Group Number:	Group Number:
Insurance Plan: (Type of coverage)	Insurance Plan: (Type of Coverage)
Insurance Address:	Insurance Address:
Insurance Phone Number:	Insurance Phone Number:
Who Referred you to this office:	Have you previously had therapy at Windwood Family Services? If yes, who did you see?
Primary Care Physician – Name & Telephone Number:	

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FORM

- I authorize the clinicians to provide from their records any information including substance abuse or any other confidential information requested by my insurance company, Medicaid, Medicare, Commercial Insurances, or other Third Party payors, in connection with payment for any incurred charges. I also authorize the clinician to provide information from my medical record to any utilization and/or quality review organization affiliates with my insurer for use in utilization management.
- I agree to pay all charges incurred by me. I assign my insurance benefits to which I may be entitled to the clinician providing the services. I understand that I am responsible for any charges not covered by this agreement.
- I permit disclosure of my Protected Health Information via electronic transmission, including e-mail and/or internet, for purposes of treatment, payment or healthcare operations. I understand that there is a possibility, althoug remote, that electronically transmitted information can be intercepted. I also understand that my clinician will comply with HIPAA requirements to safeguard and secure any information transmitted in this form.

Name of Patient: ______________________________ **Date:** ____________

Person responsible for Payment: ___________________________________

Signature of Patient and/or gurardian: ______________________________

Date: ________________________________