Compassion Mental Health Services of Pennsylvania, PLLC
Mayzon Health Center, Suites 304 & 101
3124 Wilmington Rd.
New Castle, PA 16105
Phone 724-856-8620 **Fax** 724-856-8622

CMHS
COMPASSION MENTAL HEALTH SERVICES

Demographics

Patient Information

Last name: _____ First name: _____ Middle Initial: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____ Gender: _____
Cell Phone: _____ Home Phone: _____ Email: _____
Date of Birth: _____ Social Security # _____ Marital Status: _____
Employer Name: _____ Employer Phone: _____
Preferred Language: _____
Preferred Pharmacy: _____

Responsible Party Information (for children under 18)

Last name: _____ First name: _____ Middle Initial: _____
Relationship to Patient: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____ Gender: _____
Cell Phone: _____ Home Phone: _____ Email: _____
Date of Birth: _____ Social Security Number: _____ Marital Status: _____
Employer Name: _____ Employer Phone: _____

Insurance Information

Primary

Insurance Company: _____ Member ID # _____ Group # _____
Policy Holder's First/Last Name: _____ Gender: _____
Date of Birth: _____ Social Security # _____ Marital Status: _____
Relationship to Patient: _____

Secondary

Insurance Company: _____ Member ID # _____ Group # _____
Policy Holder's First/Last Name: _____ Gender: _____
Date of Birth: _____ Social Security # _____ Marital Status: _____
Relationship to Patient: _____

Emergency Contact Info

First/Last Name: _____ Phone Number: _____
Relationship to Patient: _____

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

D3 NICHQ Vanderbilt Assessment Scale—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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11-19/rev1102

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Patient's Printed Name: _____ **Date of Birth:** _____

Medication History

Medication	Dosage	Current	Start Date	End Date	Effective	Side Effects
	Antidepressants					
Anafranil (clomipramine)		YES / NO			YES / NO	
Trintellix (vortioxetine)		YES / NO			YES / NO	
Celexa (citalopram)		YES / NO			YES / NO	
Cymbalta (duloxetine)		YES / NO			YES / NO	
Desyrel (trazodone)		YES / NO			YES / NO	
Effexor (venlafaxine)		YES / NO			YES / NO	
Elavil (amitriptyline)		YES / NO			YES / NO	
Emsom (selegiline)		YES / NO			YES / NO	
Fetzima (levomilnacipran)		YES / NO			YES / NO	
Lexapro (escitalopram)		YES / NO			YES / NO	
Luvox (fluvoxamine)		YES / NO			YES / NO	
Norpramin (desipramine)		YES / NO			YES / NO	
Pamelor (nortriptyline)		YES / NO			YES / NO	
Paxil (paroxetine)		YES / NO			YES / NO	
Pristiq (desvenlafaxine)		YES / NO			YES / NO	
Prozac (fluoxetine)		YES / NO			YES / NO	
Remeron (mirtazapine)		YES / NO			YES / NO	
Sinequan (doxepin)		YES / NO			YES / NO	
Tofranil (imipramine)		YES / NO			YES / NO	
Viibryd (vilazodone)		YES / NO			YES / NO	
Wellbutrin (bupropion)		YES / NO			YES / NO	
Zoloft (sertraline)		YES / NO			YES / NO	

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Medication	Dosage	Current	Start Date	End Date	Effective	Side Effects
	Mood Stabilizers					
Depakote (valproic acid)		YES / NO			YES / NO	
Eskalith (lithium)		YES / NO			YES / NO	
Lamictal (lamotrigine)		YES / NO			YES / NO	
Neurontin (gabapentin)		YES / NO			YES / NO	
Tegretol (carbamazepine)		YES / NO			YES / NO	
Topamax (topiramate)		YES / NO			YES / NO	
Trileptal (oxcarbazepine)		YES / NO			YES / NO	
	Antipsychotics					
Abilify (ariprprazole)		YES / NO			YES / NO	
Clozaril (clozapine)		YES / NO			YES / NO	
Fanapt (iloperidone)		YES / NO			YES / NO	
Geodon (ziprasidone)		YES / NO			YES / NO	
Haldol (haloperidol)		YES / NO			YES / NO	
Invega (paliperidone)		YES / NO			YES / NO	
Latuda (lurasidone)		YES / NO			YES / NO	
Mellaril (thioridazine)		YES / NO			YES / NO	
Navene (thiothixene)		YES / NO			YES / NO	
Prolixin (fluphenazine)		YES / NO			YES / NO	
Rexulti (brexpiprazole)		YES / NO			YES / NO	
Risperdal (risperdone)		YES / NO			YES / NO	
Saphris (asenapine)		YES / NO			YES / NO	
Seroquel (quetiapine)		YES / NO			YES / NO	
Thorazine (chlorpromazine)		YES / NO			YES / NO	
Trilafon (perphenazine)		YES / NO			YES / NO	
Zyprexa (olanzapine)		YES / NO			YES / NO	

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Medication	Dosage	Current	Start Date	End Date	Effective	Side Effects
	Anxiolytics/Hypnotics					
Ambien (zolpidem)		YES / NO			YES / NO	
Ativan (lorazepam)		YES / NO			YES / NO	
Buspar (buspirone)		YES / NO			YES / NO	
Inderal (propranolol)		YES / NO			YES / NO	
Klonopin (clonazepam)		YES / NO			YES / NO	
Librium (chlordiazepoxide)		YES / NO			YES / NO	
Lunesta (eszopiclone)		YES / NO			YES / NO	
Restoril (temazepam)		YES / NO			YES / NO	
Serax (oxazepam)		YES / NO			YES / NO	
Tranxene (clorazepate)		YES / NO			YES / NO	
Valium (diazepam)		YES / NO			YES / NO	
Xanax (alprazolam)		YES / NO			YES / NO	

Based on your responses above, if you are interested in learning about additional services provided by Compassion Mental Health Services of Pennsylvania, PLLC, including **Transcranial Magnetic Stimulation (TMS)** and **Genetic Testing**, please let your provider know. If you have additional questions or inquiries, please contact the office at 724-856-8620.

Parent Authorization, Agreement, and Consent to Treatment of Child
Legal Parent or Guardian's Consent to Treatment

I, _____, _____ of _____,
(Name of parent or legal guardian) (Relationship to child) (Name of child)

Hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child to receive mental health treatment at Compassion Mental Health Services of Pennsylvania, PLLC and assume all financial responsibility for their treatment.

I affirm that I have the authority to make healthcare decisions for my child and am aware that all custodial parents and legal guardians must give consent before treatment begins.

I understand and agree that any breach of this agreement may result in the termination of any or all of my child's relationships with Compassion Mental Health Services of Pennsylvania, PLLC or any of its providers, affiliates, or staff members. I have been given the opportunity to ask any questions that I may have had and am voluntarily signing this agreement.

Name of Parent: _____

Signature: _____ Date: ___ / ____ / _____

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Consent to Obtain Medication History Information and E-Prescribe

Compassion Mental Health Services of Pennsylvania, PLLC currently participates in an e-prescribing system. The system allows for the electronic prescribing of medications, which provides a convenience to patients and physicians and reduces medication errors. An additional portion of the service allows the electronic receiving of prescription benefits and medication history such as past prescriptions and dosages filled from other pharmacies, which also reduces error in the entry of medication. By signing below, you give Compassion Mental Health Services of Pennsylvania, PLLC permission to e-prescribe and access your information to receive such information electronically, which will become a part of your electronic medical record.

____ I consent ____ I DO NOT consent

Patient Name (printed) _____ Date _____

Patient's parent or legal guardian name (printed) _____

Signature _____

The release of information complies with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder. This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Federal rules and the regulations of the state of Pennsylvania prohibit you from making any further disclosure of this information without prior written consent of the person in respect to whom it pertains.

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this document.

The terms of the notice may change, f so, you will be notified at our next visit to update your signature/date.

You have the right to restrict how our protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments YES NO

May we leave a message on your answering machine at home or on your cell YES NO

May we discuss your medical condition with any member of your family YES NO

If YES, please name the members allowed:

_____ _____

_____ _____

This Consent was signed by: _____

PRINT NAME PLEASE

Signature: _____ Date: _____

Witness: _____ Date: _____

INSURANCE POLICY

1. Every insurance recipient must present his or her current insurance card at the time of service. If you do not have your insurance card. then you will be considered a self-pay patient.
2. If you have primary insurance with Medicaid as secondary insurance, then you must provide proof of coverage at the time of service. If you fail to disclose your primary insurance, then your claim will be denied.
3. The patient or guarantor will be responsible for all charges incurred if no insurance card is presented or if any amount is not paid or covered by his or her insurance. Services not covered by insurance will be due at the time of service. It is your responsibility to know what is covered and what is not.
4. Please notify our office if there are any changes to your insurance coverage or a change of insurance carrier.

This is to certify that I (we), the undersigned, voluntarily consent to the administration of the practice of diagnostic procedure, Imaging, or photography and medical treatment by providers, authorized agents, and employees of the practice as may, in their professional judgment, be deemed necessary or beneficial. Unless otherwise specified, all healthcare providers may obtain additional consents for individual procedures. I (we) acknowledge that no guarantees have been made to me (us) as to the effect of such examination or treatment.

I understand that the insurance benefits are provided directly to the patient or guarantor and that I, the undersigned, further agree and understand that I am directly responsible for all financial obligations to **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC**. I understand that I will be responsible for the balance due on my collections plus all fees related to the collection.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I hereby consent to the use or disclosure of my individually identifiable health information ("protected health information") by **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** in order to carry out treatment, payment, or healthcare operations. I understand that I should review **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC's** Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and I have the right to review such Notice prior to signing this Consent Form.

COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC reserves for itself the right to change the term of its Notice o Privacy Practices for Protected Health Information at any time. If **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** does change the terms of Notice of Practices for Protected Health Information, I may obtain a copy of the revised notice by calling the office and requesting a revised copy be sent in the mail or asking for a revised copy to be sent in mail at the time of my next appointment.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** is not require to agree to such requested restriction(s); however, if **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** does agree to my requested restriction(s), such restriction(s) are then binding to **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC.**

At all time, I retain the right to revoke this consent in writing, to **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** except to the extent that action has already been taken.

COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC may refuse to treat the Patient if he or she (or the Patient's authorized representative) does not sign this Consent Form (except to the extent that **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** is required by law to treat individuals). If the Patient (or the Patient's authorized representative) signs this Consent Form and then revokes consent, **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** has the right to refuse to provide further treatment to the Patient at of the time of revocation (except to the extent that **COMPASSION MENTAL HEALTH SERVICES OF PENNSYLVANIA, PLLC** is required by law to treat individuals).

I fully understand and have read the **INSURANCE POLICY** and the **CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS** and agree to abide by their policies.

Signature of patient or patient's parent or legal representative _____ **Date**

Relationship to the patient if other than parent _____ **Signature of witness**

CMHS
COMPASSION MENTAL HEALTH SERVICES

Appointment No-Shows

It is the policy of Compassion Mental Health Services to monitor and manage appointment no-shows. This is necessary to ensure that we are able to provide timely access for all patients to our providers. With a long list of patient's waiting to see the clinicians, "no-show" appointments take away time that could be spent with a patient in need.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least **24 hours prior** to the scheduled time is considered a "no-show."

After an established patient has **two consecutive** "no-show" appointments, or **four non-consecutive** "no-show" appointments, that patient and any person who is either a guarantor for, or guarantee of, the account in question may be discharged from our practice and asked to seek healthcare with another physician.

New patients seeking to establish care with Compassion Mental Health Services who fail to cancel or reschedule their initial appointments at least 24 hours prior to the scheduled appointment are also considered to be "no shows". After **one "no-show",** with no cancellation call 24 hours in advance, the new patient will not be rescheduled for an appointment.

Procedures:

1. When a patient violates "no show" policy criteria the practice management system is updated to reflect a "No show".

2. Front office staff may exercise limited discretion in assigning "no shows" so as to account for special circumstances. These special circumstances shall be narrow in scope and would meet the general test of an unavoidable circumstance experienced by the patient such as hospitalization, or another emergency.

3. The appropriate "no show" letter is prepared for the patient. It is printed on Compassion Mental Health Services letterhead and mailed to the address supplied by the patient in the practice management system.

4. An electronic copy of the letter is saved in the patient's electronic medical record.