EPIC Behavioral Healthcare

Registration Information

First Name _____ Middle Name _____ Last Name _____

Suffix _____ SSN _____ DOB _____

GENDER	RACE	ETHNICITY	MARITAL STATUS
☐ Male	☐ American Indian	☐ Cuban	☐ Never Married
☐ Female (Given on ID)	☐ Asian	☐ Haitian	☐ Married
Preferred Gender	☐ Black	☐ Mexican	☐ Widowed
	☐ Alaskan Native	☐ Mexican American	☐ Divorced
	☐ Hawaiian/Pacific Islander	☐ Puerto Rican	☐ Separated
	☐ Multi-Racial	☐ Spanish/Latino	☐ Legally Separated
	☐ White	☐ Other Hispanic	☐ Unreported
	☐ Other	☐ None of the Above	☐ Registered Domestic Partner

Do you need accomodations? ☐ Yes ☐ No

Interpreter? ☐ Yes ☐ No If yes, what language dialect? _____

Sign Language? ☐ Yes ☐ No Reading Assistance? ☐ Yes ☐ No

Assistance Filling Out Forms? ☐ Yes ☐ No

IDENTIFY ANY KNOWN DISABILITIES OF THE CLIENT		
☐ Developmentally Disabled	☐ Physically Disabled	☐ Non-Ambulatory
☐ Visually Impaired	☐ Hearing Impaired	☐ Severely Impaired English Language

Address Homeless ☐ Yes ☐ No

Mailing Address _____ _____

City _____ State _____ Zip _____

Is the above also the billing address? ☐ Yes ☐ No

Home Phone _____ Work Phone _____ Cell Phone _____

Message Phone _____

Email Address _____ @ _____

Emergency Contact Person _____

Business Phone _____ Home Phone _____

Relation to client _____

Is this person the Client's guardian? ☐Yes ☐No

Is this person Financially Responsible for the client's care? ☐Yes ☐No

What is the highest grade level you completed? _____ (Or estimate # years of schooling)

☐ No School ☐ HS Diploma/GED ☐ Some College ☐ AA ☐ BS/BA ☐ Master's ☐ Doctorate ☐ Vocational ☐ Special School

Employment Status		
☐ Active Military, Overseas	☐ Full Time	☐ Leave of Absence
☐ Active Military, USA	☐ Part Time	☐ Terminated/Unemployed
☐ Disabled	☐ Homemaker	☐ Not Authorized to Work
☐ Retired	☐ Student	☐ Criminal Inmate
	☐ Unpaid Family Workers	☐ Inmate Other

Has the client ever or are you currently serving in the military? ☐Yes ☐No

Current Tobacco Use? ☐Never used ☐Have Used/Not Current ☐Regular User ☐Use Smokeless Tobacco

Do you have Advanced Directives? ☐Yes ☐No

Are you receiving any Psychiatric Social Security Disability Income?

☐ Determined to be ineligible ☐ Eligibility determination pending ☐ Eligibility status unknown

☐ Eligible, not receiving payments ☐ Eligibile, receiving payments ☐ Potentially eligible, has not applied

CLIENT RESIDENTIAL STATUS			
☐ Independent Alone	☐ Assisted Living Facility	☐ Nursing Home	☐ Children's Residential Treatment
☐ Independent Relatives	☐ Foster Care/Home	☐ Supported Housing	☐ MH Licensed ALF
☐ Independent Non-Relatives	☐ Group Home	☐ Correctional Facility	☐ Other
☐ Dependent Relatives	☐ Homeless	☐ DJJ Facility	☐ Unknown
☐ Dependent Non-Relatives	☐ Hospital	☐ Crisis Residence	

Have you been diagnosed in past with Co-Occurring Mental Health/Substance Use Disorder? ☐ Yes ☐ No ☐ Unknown

Name of Primary Care Physician/Practice _____ Phone _____

☐ No Client does not have a Primary Care Physician

Previous Mental Health services: ☐ Yes ☐ No ☐ Unknown

If yes, where? _____

Previous Substance Treatment Services: ☐ Yes ☐ No ☐ Unknown

If yes, where? _____

Have you recently been Baker Acted to a Treatment Facility? ☐ Yes ☐ No ☐ Unknown

If yes, where? _____

********Obtain Releases of Information on any facilities listed above********

Number of Dependents _____ Total Number in Household _____

Client Monthly Income _____ Client Annual Income _____

Household/Family Annual Income _____

********Income primarily needed for anyone with insurance********

PRIMARY SOURCE OF INCOME (Must be completed)		
☐ Salary	☐ Retirement/Pension/SSI	
☐ Wages/TANF	☐ Other	
☐ Disability	☐ Unknown	☐ None

Do you have Florida Medicaid? ☐ Yes ☐ No If Yes, Medicaid # _____

Medicare Part B? ☐ Yes ☐ No If Yes, Medicare # _____

Do you have Commercial Insurance? ☐ Yes ☐ No

Name of Insurance

Insurance ID # _____ Group # _____

Is the client the subscriber of policy? ☐ Yes ☐ No

If No, Name of Subscriber _____

DOB of Subscriber _____ SSN of Subscriber _____

Address of Subscriber _____

epic
BEHAVIORAL HEALTHCARE

REFERRAL SOURCE (Check as many as apply)			
☐ Individual (Self Referral)	☐ Other Community Referral	☐ MHSA: DCF/Family Svcs	☐ Physician/Doctor
☐ Subtance Use Provider	☐ TASC/Assessment Ctr	☐ CINS (Children in Need Svc)	☐ Law Enforcement
☐ Mental Health Provider	☐ Probation/Parole	☐ Addiction Receiving Fclty	☐ Family Safety Foster Care
☐ Juvenile Justice	☐ DUI/DWI	☐ Outreach Program	☐ Family Safety Protective Svcs
☐ County Public Health Unit	☐ Pretrail	☐ DCF/ADM	☐ None of the Above
☐ School (Educational)	☐ Prison/Jail	☐ Community Hospital	☐ Other:
☐ Employee/EAP	☐ Oher Court Order	☐ State Hospital	☐ Other:

Referring Agency or Physician/Hospital _____

Reason for Referral _____

Phone Number _____ Contact Person _____

Address of Referring Person/Agency _____

City _____ State _____ Zip _____

Would you like to register to vote while you are here today? ☐ Yes ☐ No

(For any Florida resident not already registered)

STAFF CHECKLIST

- ☐ Insurance subscriber added as a contact in order to be linked to the coverage plan
- ☐ Creat coverage plan
- ☐ Apply coverage plan w/start date
- ☐ Complete Financial Worksheet
- ☐ Complete Financial Attestation if applicable
- ☐ Client Account check box Financial Information Complete
- ☐ Client information Billing address checkbox selected to billing address
- ☐ Informed Consent completed
- ☐ Registration FL document completed
- ☐ Online Therapy Consent (if applicable) completed
- ☐ HIV/TB Risk Assessment completed
- ☐ Picture of patient added to account
- ☐ Insurance cards scanned and uploaded
- ☐ Program Enrollment requested
- ☐ Release of Information to Primary Care Physician
- ☐ Release of information to any past MH, Substance Treatment or Baker Act Facilities
- ☐ Release of Information to Referral Sources
- ☐ Release of Informantion to any family members

Next should be Medical History Questionnaire
Communicable Disease Questionnaire

epic BEHAVIORAL HEALTHCARE

SNAP Assessment-Minor

Strengths, Needs, Abilities, Preferences

Client Name:_____ Date: _____

Client ID: _____ Program: _____

Check all that apply and list what is not shown.

STRENGTHS (What will help you in treatment)		**COMMENTS**
☐	Support from parents	
☐	Support from siblings	
☐	Positive school connections	
☐	Connection to a church group or minister	
☐	Supportive friends	
☐	Stable finances or benefits	
☐	Stable housing or shelter	
☐	Stable transportation or access to transportation	
☐	Established pediatrician (doctor) services	
☐	Extracurricular activities (sport, music, drama)	
☐	Others:	
☐		
☐		
☐		

NEEDS (What you want to learn in treatment)		**COMMENTS**
☐	Education about my/my child's diagnosis	
☐	Education about mental health	
☐	Education about the impact of trauma	
☐	Learn self-care	
☐	Improvement in my interpersonal skills (listening, playing well with others)	
☐	Contact with supportive others	
☐	Emotion management skills	
☐	Anger management skills	
☐	Anxiety management skills	
☐	Personal safety and recovery plan	
☐	Parenting skills	
☐	Education about improving my/my child's health	
☐	Day to day self-management (structure, goals)	
☐	Others:	
☐		
☐		
☐		

ABILITIES (Your qualities/skills that will help in treatment) **COMMENTS**

☐	I am motivated for treatment	
☐	I have insight in to my mental health concerns	
☐	I am willing to accept feedback and guidance	
☐	I am willing to take try new skills	
☐	I am able to ask for help from others	
☐	I am willing to work to grow and change	
☐	I am able to express my concerns and needs	
☐	I have some positive plans and goals for my future	
☐	I have a good relationship with a higher power	
☐	I am capable of offering support to others	
☐	I will treat myself and others with respect	
☐	Others:	
☐		
☐		
☐		

PREFERENCES (What you hope to get out of treatment) **COMMENTS**

☐	I will have a better understanding of my diagnosis	
☐	I will have a better understanding of trauma and its effects	
☐	I will learn to take care of myself	
☐	I will do better in school	
☐	I will be able to communicate more effectively	
☐	My interpersonal skills/relationships will improve	
☐	I will be able to manage my emotions	
☐	I will be able to manage my anxiety	
☐	I will be able to manage my anger	
☐	I will be able to resolve grief and loss concerns	
☐	I will develop a positive support network	
☐	My health will improve	
☐	I will improve my day to day functioning	
☐	Others:	
☐		
☐		
☐		

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HIV/AIDS/TB Risk Assessment

Please check your response to the following questions:

Shared needles/syringes? ☐ Yes ☐ No

Have you had unprotected sex within the last year? ☐ Yes ☐ No

Have you been a sex or needle sharing partner of a person with HIV/AIDS? ☐ Yes ☐ No

Have you traded sex for drugs or money? ☐ Yes ☐ No

Have you had a sexually transmitted disease? ☐ Yes ☐ No

Have you ever had an HIV test? ☐ Yes ☐ No

If yes, Date: _____ Results: _____

Are you a hemophiliac or blood transfusion recipient? ☐ Yes ☐ No

Are you a victim of sexual assault? ☐ Yes ☐ No

An injection drug user? ☐ Yes ☐ No

A person with other/HIV/AIDS risks? ☐ Yes ☐ No

Unexplained fevers? ☐ Yes ☐ No

Recent unexplained weight changes? ☐ Yes ☐ No

Client was referred to the Public Health Department for follow up? ☐ Yes ☐ No

Date of positive Tuberculosis (TB) test _____

Date of last X-ray for Tuberculosis _____

Have you ever taken medication for Tuberculosis? ☐ Yes ☐ No

Name of Medication _____

Check if you have had any of the following symptoms for 3-4 weeks

Productive Cough ☐ Yes ☐ No

Persistent weight loss without dieting ☐ Yes ☐ No

Loss of appetite ☐ Yes ☐ No

Persistent fever above 100.0 F ☐ Yes ☐ No

Night sweats ☐ Yes ☐ No

Swollen glands in the neck or elsewhere ☐ Yes ☐ No

Coughing up blood (hemoptysis) ☐ Yes ☐ No

Shortness of breath ☐ Yes ☐ No

Chest pains ☐ Yes ☐ No

Fatigue or weakness ☐ Yes ☐ No

Frequent or Recurring chills ☐ Yes ☐ No

Parent / Guardian Survey

Child's Name: _____ **Date:** _____

Parent / Guardian Name: _____

Relationship: _____

Please fill out this checklist to identify area of concern in your child's life. Your responses will help determine what kind of supports/services, if any, may benefit your child.

	No problem	Some problem	Serious problem
School Behavior			
Describe grades in school.			
Skipping classes/truancy?			
Negative attitudes toward school authorities?			
Suspension/Expulsion from school?			
Behavior at Home			
Verbally abusive toward family mambers.			
Is secretive and uncommunicative.			
Lies about where he/she has been.			
Loss of motivation - no goals.			
Irritabilty, fits of anger, temper tantrums.			
Comes home drunk or high.			
Steals from family members.			
Runs away from home.			
Stays away all night.			
Emotional/Mental State of Child			
Acts "down" and depressed for days at a time.			
Has talked about "ending it" or killing self.			
Has made a suicide attempt.			
Neglects personal hygiene and grooming.			
Exhibits radical mood swings.			

Medical Questionnaire Page 1

Patient Name: _____

Medical History

Have you had any of the following (please check box and explain if needed):

Sexually transmitted Disease(s) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Asthma Attacks Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Tuberculosis(TB) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Heart Trouble Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Condition Needing Surgery Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Diabetes Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Difficulty Hearing Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Kidney/Urination Problems Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Physical Handicap Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Rheumatic Fever Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Poor Eyesight Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Speech Defect Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Ulcer(stomach/intestine) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Serious Dental Problems Explain-Being Treated:	☐ Never	☐ Past	☐ Now
In Hospital in Last 4 Years Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Anemia Explain-Being Treated:	☐ Never	☐ Past	☐ Now

Medical Questionnaire Page 2

Medical History Continued

Have you had any of the following (please check box and explain if needed):

Suicidal in Last 3 Months Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Allergic to drugs/foods Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Pregnant (Females Only) Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Immunizations up to date Explain-Being Treated:	☐ Never	☐ Past	☐ Now
Sickle cell Explain-Being Treated:	☐ Never	☐ Past	☐ Now

Any other conditions: _____

_____

FOR ANSWERS MARKED IN THE NOW COLUMN, IT IS RECOMMENDED YOU SEEK A DOCTOR'S CARE

List all medications you are taking: _____

_____

Primary Care Physician Name: _____

Primary Care Physician Phone Number: (_____) _____-_____ **I have no Primary Care** ☐

Patient Signature: _____ Signature Date: _____

EPIC BEHAVIORAL HEALTHCARE
Sliding Fee Scale/ Financial Attestation
Effective March 1, 2023-February 28, 2024

Client Name _____ **Client ID #** _____

Federal Poverty Level Family Annual Income		ELEGIBLE FAMILY ANNUAL INCOME		HOUSEHOLD NUMBER							
Minimum Income	Maximum Income	150% Minimum Income	150% Maximum Income	1	2	3	4	5	6	7	8
				The percentage represents the clients responsibility for each chargeable service. 0% will be assessed a minimum fee of $3.00 per chargeable service. Any consumer that falls into the yellow is eligible for LSFHS funding, all others will fall under the sliding fee scale of your organization.							
$0.00	$ 14,580.00	$0.00	$ 21,870.00	0%	0%	0%	0%	0%	0%	0%	0%
$ 14,581.00	$ 19,720.00	$ 21,870.01	$ 29,580.00	5%	0%	0%	0%	0%	0%	0%	0%
$ 19,721.00	$ 24,860.00	$ 29,580.01	$ 37,290.00	10%	5%	0%	0%	0%	0%	0%	0%
$ 24,861.00	$ 30,000.00	$ 37,290.01	$ 45,000.00	15%	10%	5%	0%	0%	0%	0%	0%
$ 30,001.00	$ 35,140.00	$ 45,000.01	$ 52,710.00	25%	15%	10%	5%	0%	0%	0%	0%
$ 35,141.00	$ 40,280.00	$ 52,710.01	$ 60,420.00	35%	25%	15%	10%	5%	0%	0%	0%
$ 40,281.00	$ 45,420.00	$ 60,420.01	$ 68,130.00	45%	35%	25%	15%	10%	5%	0%	0%
$ 45,421.00	$ 55,700.00	$ 68,130.01	$ 83,550.00	55%	45%	35%	25%	15%	10%	5%	0%
$ 55,701.00	$ 60,840.00	$ 83,550.01	$ 91,260.00	65%	55%	45%	35%	25%	15%	10%	5%
$ 60,841.00	$ 65,980.00	$ 91,260.01	$ 98,970.00	70%	65%	55%	45%	35%	25%	15%	10%
$ 65,981.00	$ 71,120.00	$ 98,970.01	$ 106,680.00	75%	70%	65%	55%	45%	35%	25%	15%
$ 71,121.00	$ 76,260.00	$ 106,680.01	$ 114,390.00	80%	75%	70%	65%	55%	45%	35%	25%
$ 76,261.00	$ 81,400.00	$ 114,390.01	$ 122,100.00	85%	80%	75%	70%	65%	55%	45%	35%
$ 81,401.00	$ 86,540.00	$ 122,100.01	$ 129,810.00	90%	85%	80%	75%	70%	65%	55%	45%
$ 86,541.00	$ 91,680.00	$ 129,810.01	$ 137,520.00	95%	90%	85%	80%	75%	70%	65%	55%
$ 91,681.00	$ 96,820.00	$ 137,520.01	$ 145,230.00	100%	95%	90%	85%	80%	75%	70%	65%
$ 96,821.00	$ 101,960.00	$ 145,230.01	$ 152,940.00	100%	100%	95%	90%	85%	80%	75%	70%
$ 101,961.00	$ 107,100.00	$ 152,940.01	$ 160,650.00	100%	100%	100%	95%	90%	85%	80%	75%
$ 107,101.00	$ 112,240.00	$ 160,650.01	$ 168,360.00	100%	100%	100%	100%	100%	100%	100%	100%

Insurance Company _____ **Policy Number** _____

Number of Household _____

Household Annual Income _____

I hereby attest that my Annual household income reported is correct.

_____ _____
Date **Client Signature**

I hereby attest that I have perfomed due diligence in assessing financial eligibility for State funding.

_____ _____
Date **Employee Signature**

EPIC Behavioral Healthcare

Informed Consent for Treatment and Participant Agreement

By my signature, I understand and agree to the following:

- ✓ I have read, understand, and have been offered a copy of this Informed Consent for Treatment and Participant Agreement, which includes but is not limited to an explanation of my rights and responsibilities, complaint/grievance procedure, and confidentiality of my patient record.
- ✓ I agree to participate in the intake and assessment process, and to receive services, which could include assessment, stabilization, detoxification, medication treatment, clinical and medical services, drug screens, discharge planning, and Care Coordination services.
- ✓ I agree to follow the Program Rules as discussed.
- ✓ I understand and agree to the exchange of confidential information through Release of Information process
- ✓ I agree to participate in programmatic data collection as needed for this program
- ✓ I was informed that this consent could be revoked by me verbally or in writing, before or during the period in which I receive services, except to the extent that action has been taken on reliance on it.
- ✓ I acknowledge that there have been no guarantees or assurances made to me as the results of services rendered by EPIC, or its employees.
- ✓ I give permission to contact me for the purposes of obtaining follow up information concerning my progress after completing services.

_____

Signature of Person Served Date

_____

Guardian or Legal Custodian Signature, if applicable Date

_____

Staff Signature and Title/Credential Date

☐ Participant Agreement provided to patient.

☐ Signature Page placed in patient record.

EPIC Behavioral Healthcare
Online Therapy Consent Form

Online Therapy and Limitations
I understand that online therapy includes the practice of health care delivery, diagnosis, consultation, treatment, and education using interactive audio and video communication. I understand that discussing my presenting concerns may cause discomfort as difficult issues are addressed and worked through. This is often a common experience of psychotherapy in general and I acknowledge no guarantees have been made to me as to the effect of treatment on my condition. I understand that phone and online sessions have limitations compared to in-person sessions, among those being the lack of "personal" face-to-face interaction, the lack of visual and audio cues in the therapy process, and the fact that most insurance companies will not cover this type of therapy. I understand online therapy is not appropriate if I am experiencing crisis or having suicidal or homicidal thoughts. Should crisis occur, I agree to call 911, go to the nearest emergency room, or contact a crisis hotline (e.g. 800-273-8255).

Procedures for technical difficulties or Internet disruptions
As a client of EPIC Behavioral Healthcare, I understand that online therapy is technical in nature and that problems with the Internet may occur. If something beyond our control disrupts the connectivity of our session I will immediately try to video call the therapist again. If video call is repeatedly unsuccessful for 10 minutes, sessions will be:

1) completed via phone call to the therapist at **(904) 829-2273** or
2) refunded based on length of session prior to disruption (e.g. less than 10 minutes the session will be rescheduled at no cost, 15-30 minutes will result in half of the fee being refunded).

Appointment Payment
I agree to pay the agreed upon fee at the time of service through the EPIC Mental Health Outpatient Office in person or by phone. (e.g. through credit card or insurance on file, which will be charged the day of the appointment).

Appointment Cancellations
If cancellation is needed, I understand that notice of at least 24 hours via phone call to the office staff is necessary in order to avoid any associated fees. Cancellations with less than 24 hours notice will be billed at $25 per occurrence.

Missing an appointment without prior notice will be billed at $25 per occurrence. In addition, I understand that the accumulation of 3 late cancellations or missed appointments in any combination will result in discharge from the program.

Termination of Services
During the intake and first few sessions, the therapist will assess if online therapy is of benefit to me and my needs. The therapist will use his/her best judgment to determine if online therapy is the best medium for providing me counseling services. If online therapy is deemed inappropriate, the therapist will provide me with a number of referrals in my area so face-to-face counseling can be pursued.

Confidentiality:
Because online therapy utilizes the Internet for the transmission of personal information I understand the therapist cannot guarantee confidentiality of the personal information I provide via this form of communication. However, any information that I provide to the therapist will subsequently remain confidential and will not be given to a third party unless I give specific permission to release the information, or the therapist is required to do so by law. The issue of confidentiality is further governed by both law and ethics. I understand that the therapist follows the law and professional regulations of

the State of Florida and the counseling treatment provided will be considered to take place in the State of Florida.

By law I hold the privilege of confidentiality and the therapist will not release any information to anyone without my written permission, or a court order. There are some exceptions to my rights under the law. Examples include, but are not limited to, when the therapist has reasonable cause to believe that I am a danger to myself or another person. The therapist is also required by law to report any information about or reasonable suspicion of sexual, physical or emotional abuse of minors or elders to Child Protective Services or Adult Protective Services. I understand that if I have any concerns regarding confidentiality issues, I should speak with my therapist about these and other exceptions to the confidentiality privilege and her responsibility concerning them.

I understand EPIC Behavioral Healthcare has not given consent or release for the recording of this session outside the electronic platform used to deliver the service.

Harm to Self or Others

If there is an emergency during our work together where the therapist is concerned about my personal safety, the possibility of me injuring someone else or about my receiving proper psychiatric care, I understand the therapist will do whatever she can within the limits of the law to prevent me from injuring myself or others and to ensure that I receive the proper medical care. For this purpose, the therapist may also contact law enforcement, hospital or an emergency contact whose name I have provided.

By signing this form I agree with the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

EPIC Behavioral Healthcare
AUTHORIZATION FOR RELEASE OF INFORMATION

***I hereby authorize EPIC Behavioral Healthcare to (please check one*):**
☐ Obtain ☐ Release ☐ Exchange

the following ☐ ***written,*** ☐ ***verbal,*** ☐ ***electronic,*** ☐ ***video,*** ☐ ***audio information*** (check all that apply):

☐ Treatment goals and progress
☐ Psychological evaluation and test results
☐ Information concerning AIDS/ HIV Infection
☐ Physical exam
☐ Educational information
☐ Medical treatment
☐ Social history
☐ Behavioral observation
☐ Alcohol/drug treatment
☐ Psychiatric evaluation and treatment
☐ Other (specify) _____

(In compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(a) and Federal Regulations 42 CFR, Part 2.)

Information from the records of:

_____/_____ To/From _____

Client Name Record # (Circle one) Agency Name

_____ _____

Address Address

_____ _____

City, State, Zip City, State, Zip

_____ For information from _____ to _____

Date of Birth Date of Birth Date

For the purpose of (check one): ☐ to assist in the evaluation and treatment of the client.
☐ other (specify_____

A signed revocation may be submitted at any time, but EPIC Behavioral Healthcare shall not be held liable for any information released prior to its receipt. This release form shall be valid for (check one)

☐ A single disclosure **OR** ☐ A continuing disclosure for **90 days** from signature date below.
☐ A continuing disclosure for **1 year** from signature date below

To Receiving Agency:
PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent or the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

I acknowledge that I have read this authorization and fully understand its contents.

_____ _____/_____/_____

Signature of Client Date

_____ _____/_____/_____

Signature of legal guardian (When applicable) Date

_____

Relationship

_____ _____/_____/_____

Witness Date

PLEASE RETURN INFORMATION TO:
EPIC Behavioral Healthcare, Attn: _____, 1400 Old Dixie Highway, St. Augustine, Florida, 32084.
(Name of staff)

EPIC Staff: When requesting information, send original to other Agency. When sending information, keep original in chart.

Originated 7/03

The Patient Health Questionnaire (PHQ-9)

NAME (PRINT) _____ DATE _____

Over the last 2 weeks, how often have you been bothered by any of the flollowing problems? (Circle your answers. Please complete all 10 items.)	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired, or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that your are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
FOR HEALTHCARE PROFESSIONALS ONLY	**COLUMN TOTALS**	_____ +	_____ +	_____
	TOTAL SCORE	_____		

If you circled 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 ☐ Very difficult

☐ Somewhat difficult ☐ Extremely difficult