**Yearly Enrollment Renewal Forms**

Forms shall be completed in full and signed by the client or guardian and uploaded to the Client Set-up in the Electronic Medical Records by the provider prior to the release or disclosure of any client information.

\_\_\_ Permission for Treatment signature required

\_\_\_ Primary care physician form-required by all plans, signed by the client, completed and original mailed by provider

\_\_\_ Releases as needed such as education, psychiatrist, clinical supervisors signature required

\_\_\_ Treatment Plan Signature page, a Medicaid requirement

\_\_\_ PHQ-9 depression inventory every 4-6 months for clients with diagnosis of depression or dysthymia, a HEDIS requirement

\_\_\_ Telehealth Services form The provider must complete the information on the bottom of the form and give to the client.

**Permission for treatment/services**

Freedom of Choice
I understand that the choice of providers is my responsibility and right as the client or guardian.  I further understand that I have the right to contact the providers prior to selection so that I may determine the best provider.  I also understand that I may at any time choose another provider for this service by notifying my current provider.

Informed Consent
I understand that participation in treatment does not guarantee anticipated outcomes.  I understand that there may be unintended results of treatment affecting the client and other family/household members.  I understand that providers are legally bound to report suspected abuse of the client or of other family members.  I also understand that the providers have a duty to warn any intended victim of a threat to harm.

Persons Participating in Home and Community Based Services
I understand that I am giving permission to include in the client’s treatment sessions any persons present in the home, school or community at the time of service.  This includes but is not limited to myself, parents, spouses, step-parents, paramours, siblings, children, extended family, household visitors, caregivers, playmates and classmates.  I also understand that I have the right to dismiss anyone from participating in a session at any time and that I have the right to exclude anyone from the ongoing treatment process by written notice to the provider.

Telehealth Services

I understand that telehealth services maybe recommended as part of treatment. I have received information on the limits and process of telehealth and consent to telehealth care services.

Privacy Practices

I understand that Transformations adheres to the Health Information Privacy Act and I agree to these practices. I agree that this information has been made available to me for me review.

Responsibilities

I understand my responsibility is to: 1) provide accurate information and report any changes in client wellbeing, 2) to keep all appointments and to give 24 hour notice of a need to reschedule, 3) to maintain the client’s insurance coverage and report any lapse in coverage to the service provider, 4) to contribute to a plan of treatment and to follow through with agreed upon interventions.

I understand that I am financially responsible for any services received. I agree to report all primary and secondary insurance coverages. I agree to pay any co-pay, deductibles, and co-insurance agreed upon with my insurance company. I give permission to file insurance claims on services provided with any insurance companies with which I or my child is enrolled. I give Transformations permission to file treatment plans to request authorization for services. I also understand that a treatment plan may include information such as diagnosis, symptoms, treatment goals, and progress reports. This release includes any dependents for which Transformations staff is also providing treatment

Permission is hereby given to Transformations staff and its service providers to render screening, assessment, treatment and support services to the above-named client and under the above named conditions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian Relationship to Client

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Witness Date

**Authorization to Share Information with Primary Care Physician**

**I understand that my records are protected under the applicable state law governing health care information that relates to mental health services, KRS 304.17A-555, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This Authorization to Share Information will automatically expire one year after the date of your signature.**

**Electronic Records are preferred. Send by Fax to 502-899-5411 or**

**Secure Email at** **office@transformationsllc.net**

**Select one:**

 **\_\_\_I give permission to my Physician and to Transformations to share any applicable information from my Protected Health Information including immunization, treatments, behavioral health treatment plans, recommendations and other health care records.**

**\_\_\_I do not give my Physician and Transformations permission to share my protected health care information.**

**Primary Care Physician Name, Address, Email Address & Fax Number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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***Patient or Guardian signature please date***

**---------------------------------------------------------------------------------------------------------**

Date of consult \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis with Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and a brief description of presenting problem

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Recommendations:

\_\_\_Medication evaluation and monitoring for benefits, side effects and safety. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Medical monitoring for health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Provider/credentials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Faxed or Mailed \_\_\_\_\_\_\_\_\_\_\_\_

Transformations Hope for Today’s Families 4010 Dupont Circle Suite 582 Louisville KY 40207

Phone and Fax: 502-899-5411 Email: office@transformationsllc.net

**AUTHORIZATION TO SHARE INFORMATION**

1. I authorize Transformations & its representatives & Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4010 Dupont Circle Suite 582 Contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Louisville KY 40207 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone & fax 502-899-5411 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secure email: office@transformationsllc.net \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the purpose of sharing this information is for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that I may revoke this authorization, at anytime, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.

4. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release

5. I understand that pursuant to KRS 304.17A-555-Patient’s Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

 6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child’s identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Consumer/Guardian if Client is under 18 Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Date

**AUTHORIZATION TO SHARE INFORMATION**

1. I authorize Transformations & its representatives & Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4010 Dupont Circle Suite 582 Contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Louisville KY 40207 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone & fax 502-899-5411 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secure email: office@transformationsllc.net \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the purpose of sharing this information is for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that I may revoke this authorization, at anytime, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.

4. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release

5. I understand that pursuant to KRS 304.17A-555-Patient’s Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

 6. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child’s identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Consumer/Guardian if Client is under 18 Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Date

**AUTHORIZATION TO SHARE INFORMATION-EDUCATIONAL SYSTEM**

1. I authorize Transformations & its representatives & Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4010 Dupont Circle Suite 582 Contact Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Louisville KY 40207 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone & fax 502-899-5411 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: office@transformationsllc.net \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Electronic Records are preferred. Send by Fax to 502-899-5411 or**

**Secure Email at** **office@transformationsllc.net**

To share with one another the following items from my Protected Health Information: Psychological, psychiatric, clinical, medical and educational evaluations, records, progress summaries, contact logs, treatment plans, and progress updates both written and verbal.

Other: \_Academic and behavior reports including but not limited to IEP reports\_\_\_\_\_\_\_\_

2. I understand that the purpose of sharing this information is for: the provider to work with and support the educational system, assess the child’s behavioral needs, and provide recommendations and interventions in the academic setting.

3. I understand that I may refuse to sign this authorization and that Transformations, LLC and its Contractors will not allow my refusal to interfere with the receipt or payment of behavioral health services.

4. I understand that I may revoke this authorization, at anytime, in writing to Transformations at the address indicated below, except if Transformations or its Contractor has taken any action based on prior authorization, or obtained my authorization for the purpose of receiving reimbursement from a third party.

5. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release

6. I understand that pursuant to KRS 304.17A-555-Patient’s Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

7. I understand that pursuant to 45 CFR 46.101(b.2) only data that has been separated from my child’s identifiable information may be used for research and program development purposes, unless written consent by signing this form is provided.

I have read and understand this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Consumer/Guardian if Client is under 18 Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Date

**Treatment Plan Signature Page**

# TEAM MEMBERS’ SIGNATURES

I agree with the treatment plan and acknowledge that I had an opportunity to participate in the development of the plan. I have also been made aware of my right of Freedom of Choice among sub-providers authorized to provide each service on the treatment plan.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal guardian/Caregiver ( if child is under 18) Date Client Date

As a team member, I understand that I am to keep all information shared about the child confidential.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­Behavioral Health Professional (Required) Agency NPI # Date

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Supervisor Signature & Credentials Agency NPI # Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Targeted Case Manager (Required) Agency NPI # Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature & Credentials Agency NPI # Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Agency Date

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Other Agency Date

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Other Agency Date

**PHQ-9 Patient Questionnaire**

In an effort to provide the highest standard of care and meet the requirements of your insurance company, we ask that you fill out the form below. This form is used as both a screening tool and a diagnostic tool for depression. Your provider will discuss the form with you during your visit. Thank you for your cooperation and the opportunity to care for you.

 Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

Not Several More than Nearly

at all=0 days=1 half the every

 days = 2 day=3

1. Little interest or pleasure in doing things ⁮ ⁮ ⁮ ⁮

2. Feeling down, depressed, or hopeless. ⁮ ⁮ ⁮ ⁮

3. Trouble falling/staying asleep, sleeping too much. ⁮ ⁮ ⁮ ⁮

4. Feeling tired or having little energy. ⁮ ⁮ ⁮ ⁮

5. Poor appetite or overeating. ⁮ ⁮ ⁮ ⁮

6. Feeling bad about yourself – or that you are ⁮ ⁮ ⁮ ⁮

 a failure or have let yourself or your family

 down.

7. Trouble concentrating on things, such as ⁮ ⁮ ⁮ ⁮

 reading the newspaper or watching television.

8. Moving or speaking so slowly that other people ⁮ ⁮ ⁮ ⁮

 could have noticed. Or the opposite – being so

 fidgety or restless that you have been moving

 around a lot more than usual.

9. Thoughts that you would be better off dead or of ⁮ ⁮ ⁮ ⁮

 hurting yourself in some way.

 Add columns + + = Total score

1. If you checked off any problem on this questionnaire so far, 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

 ⁮ ⁮ ⁮ ⁮

Total Score and Depression Severity: 1-4 minimal 5-9 mild 10-14 moderate 5-19 moderately severe 20-27 severe

**Telehealth Services of Transformations hope for today’s families**

Definition of telehealth services: Telehealth includes the delivery of HIPAA compliant health care services and public health via information and communication technologies or use of other electronic media to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care and includes remote patient monitoring, synchronous interactions and asynchronous store and forward transfers of images an data.

Transformations may offer telehealth services in conjunction with regularly scheduled in-person therapy for the purpose of enhancing our ability to provide a supportive wraparound service.

Telehealth, without regularly scheduled in-person sessions, are not appropriate for the client who experiences reoccurring crises or emergencies; is suicidal or likely to become suicidal, is violent or likely to become violent, or otherwise poses a risk to themselves or others.

Transformations providers will use a secure encrypted HIPAA and HITECH compliant asynchronous or synchronous video conferencing service for all telehealth services. Social media, Facetime and phone calls are not eligible for telehealth services.

Telehealth sessions are not recorded unless the client signs a form consenting to the video taping of sessions.

Telehealth services are subject to disruption due to the nature of communication technology. The client and provider shall develop a plan to manage disrupted sessions and the rescheduling of the service.

The service provider will document the telehealth session in the client’s medical record.

The provider shall meet all the requirements of his or her licensing board for education, training, and practice of telehealth services.

The client may not be eligible for telehealth services across state lines or international boundaries.

The client is required to produce a valid photo identification.

Client’s receiving telehealth services must have a crisis plan and a treatment plan that identifies in-person emergency services and coordination of care with other professionals. Telehealth services shall be added to the treatment plan for services provided.

Kentucky Medicaid and the associated Managed Care Organizations may provide payment of telehealth services for eligible members. Co-pays apply as indicated in the client plan. Eligibility and coverage will vary with commercial insurance plans.

The service provider shall provider the client with alternative means of contact including the provider’s phone number and email address. Texting is not a secure encrypted form of communication and should only be used by the client with this understanding.

The service provider shall provide the client with his or her license type, license number, and state board access.

Provider Name

Licensing type

License #

Licensing Board website address:

Phone

Email address