Treasure Coast Community Health
Patient Contract for Behavioral Health Services

As a patient of TCCH who is requesting Behavioral Health services I understand that there are several terms and conditions that I must abide by in order to receive services.

By initialing all of the terms I am agreeing that I understand what is expected of me while I am receiving services at TCCH.

_____I understand that TCCH has an automated call system and I must respond accordingly to confirm my appointment.

_____I understand that if I arrive **7 minutes late** for my scheduled 30 minute appointment, I will be rescheduled. I understand that if I arrive **15 minutes late** for my scheduled 1 hour appointment, I will be rescheduled.

_____I have been given Behavioral Health contact information should I have the need to reschedule my appointment.

_____I understand it is my responsibility as a patient to keep my phone number, address, and insurance updated with TCCH.

_____I understand that as a patient receiving Behavioral Health services, I may be asked to randomly submit to a urine drug screen. This urine drug screen will be paid for at my expense if I am not insured. If I refuse said testing, it could jeopardize continuation of my Behavioral Health care at TCCH.

_____If I fail to comply with treatment plan(s) instituted by my Therapist or Healthcare Provider, this could jeopardize continuation of my care at TCCH.

_____If I should be discharged from TCCH for Behavioral Health services, I understand that I will only receive "Emergency Care" for thirty (30) days.

Patient Prescriptions Contract to Include Controlled Substances

Controlled substance medication (i.e. narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled and monitored by Federal, State, and local Government. Controlled substances are intended to relieve symptoms related to, or associated with my current diagnosis, to improve function and/or ability to work.

My healthcare provider may be prescribing such medication to me in addition to my regularly prescribed medication, *by initialing all of the terms*; I am agreeing that I understand what is expected of me while I am receiving these medication(s).

_____I am responsible for my prescription and/or controlled substance medication(s). If the prescription(s) is lost, misplaced or stolen, or I do not take my medication as prescribed, I understand I can request a new prescription; however, after a review of my healthcare record, my prescription may not be replaced/renewed.

_____I will keep my provider apprised of all medications I am currently taking or when I have medication(s) added/discounted from my medication regime.

_____I will call or make a request via my patient portal, at least forty-eight (48) hours ahead to request a prescription refill.

_____I understand that my main treatment goal is to improve my overall health and ability to function and/or work.

_____I will call immediately if I am experiencing any side effects from medication that has been prescribed by my TCCH healthcare provider.

_____I understand abrupt discontinuation could lead to serious side effects or emotional consequences, I agree to discuss the decision first with my physician.

Privacy & Confidentiality Statement

Florida Law requires that Behavioral Health Providers maintain confidentiality of patient information. Records are confidential and the patient has a privilege to prevent their Behavioral Health Provider from disclosing confidential communications or records. There are several exceptions (limits of confidentiality) as follows:

1. If the patient (adult or minor) declares intention to harm him/herself or other(s).
2. If the Behavioral Health Provider knows or has reasonable cause to suspect that a minor is abused, neglected or abandoned.
3. Information revealing any abuse, neglect or exploitation of any disabled adult or elderly person.
4. If a patient needs to be involuntarily hospitalized due to debilitating effects of mental illness and/or alcoholism.
5. If the patient is required to undergo a court ordered examination.

Otherwise, **NO** information or records may be released without the **written consent** of the patient or parent/guardian.

Release of Personal Health Information. Any request for records to be sent to another party must be requested in writing. Records will be sent only to those individual's or agencies specified in the release.

Therapy Services

Psychological Services – Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration or loneliness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits. Therapy often leads to a significant reduction of feeling distressed, increased skill for managing stress, and resolution to specific problems. There are no guarantees about what will happen. Psychotherapy requires a very active effort on the part of the patient.

The first session will involve a comprehensive evaluation of your or your child's needs. At the next session, a treatment plan will be reviewed with you or your child. You will have the opportunity to discuss the treatment plans.

Appointments – Appointments with a Therapist are ordinarily between 45-50 minutes in duration, once per week, although some session may be more or less frequent as needed. The time scheduled is **assigned to you and you alone.** TCCH request that you provide a 24 hour notice if it is necessary to cancel or reschedule an appointment.

Crises Contact – If at any time you are in crises or unable to keep yourself or another safe and unable to reach your therapist, call 911 or go to the nearest emergency room department.

Print Patient Name	Patient or Parent/Guardian Signature	Date
TCCH Staff Member Name	TCCH Staff Member Signature	Date

Welcome to Treasure Coast Community Health
Behavioral Health Services

This is a commitment between you and your provider. Due to the high demand for Psychiatric and therapeutic services in our community, it has become necessary to streamline our cancelation and scheduling process. This document summarizes TCCH procedures regarding patient responsibilities in this regard.

You, the patient and/or responsible adult of a minor patient, agree to **cancel appointments one business day ahead of the scheduled appointment**, and to confirm any appointments going forward.

If you do not call to cancel and confirm your next appointments, TCCH agrees to send one reminder letter regarding your future appointments. If you do not reply to the reminder letter, TCCH will understand that you are cancelling treatment and will cancel your future appointments.

Thank you for your anticipated understanding and cooperation in this matter. Our goal is to provide quality service to all those in need, and our cancelation procedures will further enable us to succeed in our mission.

Please sign below to indicate you have read and understand the scheduling procedures as outlined above.

Patient's Name	Patient's Signature
Parent/Legal Guardian Name (If applicable)	Date
Witness	

Patient Name: Date of Birth:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

Patient Name: Date of Birth:

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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