NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH

PATIENT DEMOGRAPHIC FORM		TODAY'S DATE:
Name:		**Social Security #:**
Maiden/Other Names:		**Date of Birth**:
Address:		
City:	**State**:	**Zip**:
Primary Phone: Ok to leave message? ☐ Yes ☐ No		**Alternate Phone:**
Email Address:		
Appointment Reminder Preference (Select One): ☐ Primary # ☐ Alternate # ☐ Mail ☐ email ☐ Other:		
Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other:		
Gender: ☐ Male ☐ Female ☐ Transgender (☐ M-F or ☐ F-M) ☐ Other:		
Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Others:		
Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other:		
Are you working? ☐ Yes ☐ No **If yes, Employer**:		
Marital Status: ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced ☐ Living Cooperatively		

Preferred Language:	**Race:**	**Ethnicity:**	**Tobacco Use (Smoking/Vaping)**
☐ English ☐ Spanish ☐ Other:	☐ Black ☐ White ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Native American ☐ Alaskan Native ☐ Bi-Racial ☐ Other:	**Hispanic / Latino** ☐ Yes ☐ No	☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day ☐ Unknown

Are you currently in School? ☐ No ☐ Yes If yes, School/Grade: _____
If no, please note highest grade completed: ☐ Less than High School ☐ Some High School ☐ GED
☐ High School Graduate ☐ Some College ☐ Associates Degree ☐ Bachelor's Degree ☐ Other:

Military Service: ☐ Active ☐ Reserves ☐ Honorable Discharge ☐ Medical Discharge
☐ Dishonorable Discharge ☐ None If Yes, what Branch did you serve in:

Do you have animals/pets in your home? ☐ No ☐ Yes, specify: _____

Do you have firearms or weapons in your home? ☐ No ☐ Yes, specify type: _____

Religion (specify):

Do you have any Special Needs? ☐ No ☐ Yes, Describe *(e.g. related to reading, seeing, hearing, etc):*

Do you have any Known Allergies? ☐ No ☐ Yes, Describe:

Referral Information	
How did you hear about us? ☐ Self/Walk-in ☐ Friend ☐ Family ☐ Social Media ☐ Other:	
Reason for Referral/Treatment:	
Do you have a Care Manager? ☐ No ☐ Yes	
If Yes, Care Manager Name/Agency:	**Phone**:
Do you have a Medical Doctor? ☐ No ☐ Yes	
If yes, Doctor's Name:	**Phone**:

Emergency Contact Information		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Additional Information:		

For Office Use Only - Entered by: _____ Date: _____
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NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

PSYCKES CONSENT FORM
Niagara County Department of Mental Health & Substance Abuse Services

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org**, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

☐ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

☐ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative	Date

Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

PSYCKES Information and Consent

1 **How providers can use your health information.** They can use it only to:

- Provide medical treatment, care coordination, and related services.
- Evaluate and improve the quality of medical care.
- Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2 **What information they can access.** If you give consent, Niagara County Department of Mental Health and Substance Abuse Services can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4 **Who can access your information, with your consent.** Niagara County Department of Mental Health and Substance Abuse Services's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Niagara County Department of Mental Health and Substance Abuse Services. Staff members who perform the duties listed in #1 above also can access your information.

5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:

- Niagara County Department of Mental Health and Substance Abuse Services at **716-439-7410**, or the NYS Office of Mental Health Customer Relations at **800-597-8481**.

6 **Sharing of your information.** Niagara County Department of Mental Health and Substance Abuse Services may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Niagara County Department of Mental Health and Substance Abuse Services, or until the day you withdraw your consent, whichever comes first.

8 **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to Niagara County Department of Mental Health and Substance Abuse Services. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling Niagara County Department of Mental Health and Substance Abuse Services at **716-439-7410**. Please note, providers who get your health information through Niagara County Department of Mental Health and Substance Abuse Services while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

HEALTH SCREENING FORM

NAME:_____ **DOB:**_____

Sex assigned at Birth: ☐ male ☐ female **Gender Identity:** ☐ male ☐ female ☐ transgender ☐ nonbinary ☐ other_____

Height: _____**feet** _____**inches** **Weight:** _____pounds

1. PRIMARY CARE INFORMATION

a. **Do you have a primary medical doctor (PMD)?** ☐ No ☐ Yes - **If yes,** please provide PMD name, address, phone number below

PHYSICIAN/PROGRAM NAME	ADDRESS	TELEPHONE NUMBER

b. **When did you last see your PMD (approximate date / year):** _____

c. **Have you had a health physical within the last year?** ☐ No ☐ Yes – if yes, when? _____

d. **Have you had bloodwork done in the last year?** ☐ No ☐ Yes – if yes, most recent date _____

e. **Do you have any medical issues that have not been addressed?** ☐ No ☐ Yes – if yes, describe:
_____

2. GENERAL HEALTH/HABITS / SYMPTOMS / ILLNESS

Have the following changed in the last year?	NO	YES	IF YES, EXPLAIN.
Appetite	☐	☐	
Weight	☐	☐	
Sleeping Habits	☐	☐	
Energy Level	☐	☐	
Amount of water you drink daily	☐	☐	
Urination frequency	☐	☐	

DO YOU	NO	YES	IF YES, HOW MUCH / OFTEN?
Exercise	☐	☐	
Smoke	☐	☐	
E –Cigarettes / Vaping	☐	☐	
Chew Tobacco	☐	☐	
Drink Alcohol	☐	☐	
Drink Coffee, Tea or other caffeinated drinks	☐	☐	
Use Drugs	☐	☐	

HAVE YOU EVER HAD	NO	YES	IF YES, EXPLAIN
Blurred Vision	☐	☐	
Ringing in your Ears / Hearing Loss	☐	☐	
Head Injuries	☐	☐	
Weakness, Light Headedness, Dizziness	☐	☐	
Rapid Heart Beat	☐	☐	
Pains / Discomfort or Tightening in Chest	☐	☐	
Discomfort or Shortness of Breath	☐	☐	
Breathing Problems when Asleep	☐	☐	
Pain or Discomfort in Arm, Joint, Leg	☐	☐	
Swollen Legs, Ankles, or Feet	☐	☐	
Frequent Nausea or Vomiting	☐	☐	
Discomfort when Swallowing	☐	☐	
Burning Sensation after Eating Food	☐	☐	
Discomfort After Eating	☐	☐	
Frequent Diarrhea or Constipation	☐	☐	
Painful or Bloody Bowel Movements	☐	☐	

Continued on back ⟹

3. HAVE YOU or a BLOOD RELATIVE EVER HAD any of the following conditions:

	YOU NO	YOU YES	IF YES, EXPLAIN / Dates / TREATMENT	BLOOD RELATIVE If YES, √
Painful Urination or Bloody / Dark Urine	☐	☐		☐
Loss of urine when laughing, sneezing, coughing, jumping	☐	☐		☐
Diabetes or sugar in urine	☐	☐		☐
Tendency to Bleed or Bruise Easily	☐	☐		☐
Cancer or tumor	☐	☐		☐
Heart trouble	☐	☐		☐
Epilepsy/seizures/convulsions	☐	☐		☐
Stroke	☐	☐		☐
Thyroid problems or goiter	☐	☐		☐
Allergies / Hay fever	☐	☐		☐
Asthma	☐	☐		☐
COPD / Emphysema	☐	☐		☐
Ulcers / stomach – duodenal	☐	☐		☐
High cholesterol	☐	☐		☐
High blood pressure	☐	☐		☐
Problems with your teeth (dental problems)	☐	☐		☐
Any major surgery	☐	☐		☐
Any serious accident or injury	☐	☐		☐
Hospitalization for medical illness	☐	☐		☐
Mumps	☐	☐		☐
Scarlet Fever	☐	☐		☐
Chicken Pox	☐	☐		☐
Measles/German Measles	☐	☐		☐
Rheumatic Fever	☐	☐		☐
Hepatitis A	☐	☐	**If yes, did you receive medical care?** ☐ No ☐ Yes	☐
Hepatitis B	☐	☐	**If yes, did you receive medical care?** ☐ No ☐ Yes	☐
Hepatitis C	☐	☐	**If yes, did you receive medical care?** ☐ No ☐ Yes	☐
Tuberculosis	☐	☐	**If yes, did you receive medical care?** ☐ No ☐ Yes	☐
TB (tuberculosis) test	☐	☐	**If yes, date of last PPD test:** _____ **Result of TB Test:** ☐ Negative ☐ Unknown ☐ Positive- if positive, did you receive medical care? ☐ No ☐ Yes	☐
Chest x-ray for TB	☐	☐	**If yes, date of last x-ray for TB:**	☐
HIV Test	☐	☐	**If yes, date of last test:** _____ **Result of HIV Test:** ☐ Negative ☐ Unknown ☐ Positive- if positive, did you receive medical care? ☐ No ☐ Yes	☐
Sexually Transmitted Disease (STD)	☐	☐	**If yes, did you receive medical care?** ☐ No ☐ Yes	☐
Other Communicable Disease	☐	☐		☐
Other (specify)	☐	☐		☐

IF FEMALE	NO	YES	IF YES, EXPLAIN
Are you pregnant	☐	☐	
Are you in menopause	☐	☐	
Do you have any vaginal itching, burning, discharge	☐	☐	
Do you have tender breasts or discharge from nipples	☐	☐	
Have you had a menstrual cycle / period	☐	☐	**If yes, date of last period**
Have you had a Pap Smear	☐	☐	**If yes, date of last pap smear**
Have you had a Mammogram	☐	☐	**If yes, date of last mammogram**

Continued on next page ⇨

HEALTH SCREENING FORM Continued

NAME:_____ **DOB:**_____

4. MEDICATIONS List all medications that you are currently taking, including prescribed and non-prescribed / over the counter medication

MEDICATION NAME	AMOUNT / DOSE	FREQUENCY (HOW OFTEN)

5. RISK BEHAVIORS

a. How many sexual partners have you had? _____

b. Do you use condoms and/or other protective devices when engaging in sexual activities?
☐ No ☐ Yes

c. Have you ever.....	No	Yes
Had sex while high on drugs or alcohol	☐	☐
Had sex to get money, drugs, shelter, etc.	☐	☐
Paid for sex with money, drugs, etc.	☐	☐
Had sex with an individual who injects drugs	☐	☐
Had unprotected sex	☐	☐
With someone who was HIV positive	☐	☐
Whose HIV status you did not know	☐	☐
Had sex against your will	☐	☐

d. Do you inject / have you injected drugs?
☐ No – skip to next question e.
☐ Yes – if yes, please answer the following questions:

What kind of needles do you / did you use?

	No	Yes
New	☐	☐
Bleached	☐	☐
Shared (someone used ***before*** me)	☐	☐
Shared (someone used ***after*** me)	☐	☐
Reused my own	☐	☐
I don't know where they came from (origin unknown)	☐	☐

e. Do you have any medical concerns that may interfere with your treatment or that you need assistance with? ☐ No ☐ Yes – please describe in the box below:

Please sign and date this form below:

CLIENT SIGNATURE **DATE**

Continued on back page ⇨

This box for clinic use only

Body Mass Index (BMI) Calculation: _____

Comments/Recommendations:

Schedule for Health Physical ☐ Is at Higher Risk ☐ Other Issues identified above ☐

Medical Needs Have Been Reviewed/Assessed by Qualified Health Professional

Printed Name of Qualified Health Professional: _____

_____ / _____

Signature of Doctor / Nurse / Qualified Health Professional that completed review Date

(Rev/MGD/11-2021)
COMMON\FORMS\ClinicFormsCurrent Health Screening

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

INFORMATION ABOUT SERVICES & CHARGES

CLIENT NAME: _____ **DATE OF BIRTH:** _____

HEALTH INSURANCE COVERAGE:

- **MEDICAID**: NO ☐ YES ☐ APPLIED ☐ ID#_____
- **MEDICARE**: NO ☐ YES ☐ ID#_____
- **OTHER HEALTH INSURANCE**: NO ☐ YES ☐

  NAME OF INSURANCE COMPANY_____

  ADDRESS_____

  ID# _____ GROUP#_____

  EFFECTIVE DATE_____ EXPIRATION DATE_____

  SCOPE OF COVERAGE: SINGLE ☐ FAMILY ☐

  SUBSCRIBER'S NAME_____

  GROUP NAME/# _____
- **NO INSURANCE**: ☐

CONSENT FOR RELEASE OF INFORMATION/ASSIGNMENT

I hereby authorize my insurance company or other agents paying for my treatment to receive information from the Niagara County Department of Mental Health & Substance Abuse Services (NCDMH) for purposes of quality assurance monitoring, utilization review and payment of claims. Additionally, my treatment provider and my insurance company may consult with each other to ensure the appropriateness of my care. This release shall remain in effect until one year after my last treatment or until the time I revoke this release. I may revoke this release at any time by notifying my treatment provider in writing. I authorize payment of medical benefits to NCDMH.

_____ _____

Client or Legal Guardian Signature Date

_____

Legal Guardian Name (printed) if applicable

_____ _____

Witness Signature Date

_____

Witness Name (printed)

FINANCIAL AGREEMENT FORM

I understand and agree that under the following circumstances I am responsible for the amount agreed upon between the Niagara County Department of Mental Health & Substance Abuse Services (NCDMH) – Niagara County Counseling and Wellness Services (NCCWS) Clinic representative and myself.

☐ I have no Third Party Insurance Coverage. **Sliding Scale Fee:** _____

☐ My Third Party Insurance does not cover my treatment. **Fee:** _____

☐ My Third Party considers NCCWS to be an out-of-network provider. ***Fee:** _____
Staff to follow the No Surprise Act Policy

I understand that I am responsible for all applicable copays and deductibles.

_____ _____
Client or Legal Guardian Signature Date

_____
Legal Guardian Name (printed) if applicable

_____ _____
Witness Signature Date

_____
Witness Name (printed)

IF NO INSURANCE, please complete the following:

Name:_____Number in Household_____
Employer:_____
Employer Address & Phone Number: _____

List ALL Household Income:

INCOME	INDIVIDUAL	SPOUSE
NET SALARY (WK, MTH, YR)		
ALIMONY		
CHILD SUPPORT		
VA BENEFITS		
UNEMPLOYMENT		
SSI / SSD		
PUBLIC ASSISTANCE		
FOOD STAMPS		
OTHER *(specify)*		
TOTAL		

LIST ANY <u>EXTRA ORDINARY</u> EXPENSE (example: large medical bills, child support, alimony or other court ordered expenses) _____
_____