ADULT

CORSICA RIVER MENTAL HEALTH SERVICES, INC.

120 BANJO LANE
CENTREVILLE, MD 21617
Phone - (410) 758-2211
Fax - (410) 758-0698

933 S. Talbot Street
ST. MICHAELS, MD 21663
Phone - (410) 745-8028
Fax - (410) 745-0492

502 POPLAR STREET
CAMBRIDGE, MD 21613
Phone - (443) 225-5780
Fax - (443) 225-5783

Thank you for your interest in Corsica River Mental Health Services, Inc. The enclosed packet contains the items you will need to complete prior to coming into the clinic for open enrollment for services. Along with the enclosed packet of information, we also need you to bring the following documentation: **Failure to have this will result in registration having to be post-poned until documentation is obtained.**

- ☐ All current Insurance Cards - primary and secondary*
- ☐ Photo ID
- ☐ Patient Social Security Card
- ☐ Primary Medical Doctors name, address and phone number
- ☐ List of all Medications

It is requested you bring the following, if applicable:

- ☐ Reports from previous psychological evaluations/testing
- ☐ Copies of important school records/ Individualized Education Plan (IEP)

* If you/your child currently has no insurance, please bring in the following for income verification:

- ☐ 3 most current pay stubs

OR

- ☐ Prior Year tax return

REGISTRATION FOR SERVICES DAYS AND TIMES:

Please check our website or call one of the numbers above for Clinic hours.

Acceptance and schedule for Intake is dependent on qualifying for services and, if required, obtaining authorizations for services.

Failure to provide all necessary documents can result in no registration.

****** Please be advised: There is a Wait List for ALL Private insurance. In order to be added to the list, Registration process must be completed. ******

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IMPORTANT POLICY INFORMATION AFFECTING CLIENTS

MEDICATION REFILL POLICY:

Please allow 7 days to complete any refill requests. If you wait until you are our of medication, we cannot guarantee that we can complete your request on time.

PRESCRIPTION POLICY:

It is policy of CRMHS to not prescribe any Schedule II Controlled Substances. This includes the following medications:

Klonipin / Clonazepam
Ativan / Lorazepam
Diazepam / Valium
Alprazolan / Xanax

CLINICAL OPINION POLICY

CRMHS will not render clinical opinion on any matter related to competence, custody and/or visitation, quardianship, parental rights or any other legal matter which involves making a judgement that is based on information that cannot be obtained in the process of the traditional therapeutic relationship. CRMHS will not write any letters of support in this area.

RELEASE OF INFORMATION/ACCESS TO MENTAL HEALTH RECORD:

CRMHS will treat all requests for access and/or release of information records and information to clients and/or parent/guardians of a client in the same manner. An appropriate and documented release of information must be in the file for any outside agency and/or person requesting records, appointment verification, etc.

NON-PAYMENT POLICY

All clients are expected to pay their share of the cost of service at the time service is rendered, for example; co-payments/deductibles/co-insurance or self pay clients. Any client that has a unpaid balance of more than $100, must pay their co-pay plus 10% of the balance owed at each visit until balance is paid in full. CRMHS administrative office reserves the right to reschedule appointments if clients are not able to pay at time of service. CRMHS will assist clients in accessing any applicable entitlements that can reduce or eliminate the financial burden of service.

Corsica River Mental Health Services, Inc.
Client Information / Referral Form
PLEASE PRINT CLEARLY

Date: _____

Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone#: (home) _____ (work) _____ (cell) _____

Social Security #: _____ Date of Birth: _____

Age: _____ Race: _____ Marital Status: _____ Gender: ☐ Male ☐ Female

Primary Care Physician: _____ Phone#: _____

Address: _____

Date last seen: _____ Immunizations Current **(for minors)**: ☐ Yes ☐ No If no, please explain: ___

_____

Allergies: _____

Employed: ☐ Full Time ☐ Part Time ☐ Not Employed

Employer: _____

Address: _____ Phone: _____

Spouses Employer (if applicable): _____

Address: _____ Phone: _____

Insurance Provider: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ County: _____

Phone#: (home): _____ (work) _____ (cell) _____

Social Security # _____ Date of Birth: _____

Secondary Insurance Provider: _____ Policy # _____ Group #: _____

Policy Holder's Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____ County: _____

Phone#: (home): _____ (work) _____ (cell) _____

Social Security # _____ Date of Birth: _____

Primary Emergency Contact

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

See Reverse Side

Client Name _____

Two Additional Emergency Contacts **(required if the client in a minor)**

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

Name: _____ Address: _____

Phone #: (home/cell) _____ (work) _____ Relationship: _____

Referral Information

Person/Agency Referring: _____ Relationship: _____

Contact Info: Phone #: _____ Fax: _____ Email: _____

Reason for Referral _____

_____

_____

Prior mental health treatment (include names, dates of psychiatric hospitalizations): _____

_____

_____

_____

_____

_____

Current Medications: _____

_____

Substance Abuse History: _____

_____

Legal Issues / Guardianship/ Court Orders / Probation: _____

_____

Suicidal / Homicidal / Paranoid Ideations / Hallucinations: _____

_____

Are you a Veteran? ____ Yes ____ No Did you serve in Iraq and/or Afghanistan conflicts? ___ Yes ___ No

If client is a minor please complete the Child Adolescent Questionnaire.

Mental Health Screening Form-III(MHSF-III) Screening Instrument

Screening Date_____

Number of days since last use of alcohol and/or other drugs_____

I am going to ask you some questions and please note the each item refers to your entire life History, not just your current situation, this is why each question begins – "Have you ever..."

1. Have you ever talked to a psychiatrist, therapist, social worker or counselor about an emotional problem? YES_____ NO_____
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help ? YES_____ NO_____
3. Have you ever been advised to take medication for anxiety, depression, hearing voices or for any other emotional problem? YES_____ NO_____
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES_____ NO_____
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see or hear? YES_____ NO_____
6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions or thought about killing yourself? YES_____ NO_____
   Did you ever attempt to kill yourself? YES_____ NO_____
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES_____ NO_____
8. Have you ever experienced any strong fears? For example of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? YES_____ NO_____
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? YES_____ NO_____
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES_____ NO_____
11. Have you ever experienced any emotional problems associated with your sexual interests, you sexual activities or you choice of sexual partner? YES_____ NO_____

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw-up? YES_____ NO_____

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES_____ NO_____

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

YES_____ NO_____

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying or maintaining very rigid schedule of daily activities from which you could not deviate.

YES_____ NO_____

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES_____ NO_____

17. Have you ever been told by teachers, guidance counselors or others that you have a special learning problem? YES_____ NO_____

SCORE:(Questions 1 and 2 are not scored)

Number of "YES" answers_____

*Screened positive = a score of 1 or greater

F.X. Carroll, PHD and John J. McGinley, M.S.,M.S.W., Project Return Foundation 2000

CAGE-Adapted to Include Drugs (CAGE-AID) Screening Instrument

Screening Date: _____

1. Have you ever felt you should Cut down on your drinking or drug use?

   Drinking: YES _____ NO _____

   Drug Use: YES _____ NO _____

2. Have people Annoyed you by criticizing your drinking or drug use?

   Drinking: YES _____ NO _____

   Drug Use: YES _____ NO _____

3. Have you ever felt bad or Guilty about your drinking or drug use?

   Drinking: YES _____ NO _____

   Drug Use: YES _____ NO _____

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

   Drinking: YES _____ NO _____

   Drug Use: YES _____ NO _____

SCORING

SCORE: Number of "Yes" Answers _____

- Screened positive = a score of 1 or greater

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