Catalyst
BEHAVIORAL HEALTH

Name (Last) _____ (First) _____ (Middle) _____
Address: _____ Home Phone # ( ) _____-_____ Cell # ( )_____-_____
City: _____ State: _____ Zip: _____
Date of Birth: _____/_____/_____ Soc. Sec#_____-_____-_____ Male: ☐ Female: ☐
Race: _____ Ethnicity: ☐ Hispanic or Latino ☐Not Hispanic or Latino Preferred Language:_____
Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐ In a Relationship: ☐ Engaged: ☐ Other: ☐
Email Address: _____

Parent/Spouse/Guardian's Name: _____ Soc. Sec#_____-_____-_____
Purpose of Visit: _____
Emergency Contact/Next of kin: _____ Phone: ( ) _____-_____
Primary Care Physician: _____Phone: ( ) _____-_____
Were you referred to our office? Yes: ☐ No: ☐ Referral Source: _____

Do You Have Medical Insurance? Yes ☐ No ☐ **(If Yes Please Answer ALL Questions Below)**
Primary Insurance Company_____
Member ID #_____ Group#_____
Does your insurance require authorization prior to the first session? Yes ☐ No ☐ Not Sure ☐
If yes, have you contacted the company? Yes ☐ No ☐
Policy Holder's Name & Relationship_____
Policy Holder's Soc. Sec#_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____
Policy Holder's Employer's Name_____ Employer's Phone #: ( ) _____-_____
Employer's Address_____

Secondary Insurance Co._____
Policy #_____Group #_____
Policy Holder's Name & Relationship_____
Policy Holder's Soc. Sec #_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____
Policy Holder Employers Name: _____ Employer's Phone ( ) _____-_____
Employer's Address_____

Responsible Party or Guarantor (if other than patient): _____
Address: _____ Phone: ( ) _____-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Dr. Tracy List, Ph.D., LLC that is otherwise payable to me for her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Tracy List, Ph.D., LLC will be credited to my account in accordance with the above assignment.

_____ _____ _____
(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

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Consent for Treatment

Patient's Name: _____ **Patient's DOB:** _____

I, _____, hereby give my consent to Dr. Tracy List, Ph.D., LLC to provide mental health services to me;

and/or I, _____ (Parent/Guardian) to the above-named patient, hereby give my consent for treatment.

I understand that:

- Dr. Tracy List may send my medical record information to my insurance company.
- I must pay my share of the costs (e.g., co-pays, amounts until a met deductible, etc.)
- If I do not have insurance, or if my insurance does not cover mental health services, I must pay for these services in full.

I understand that:

- I have the right to refuse any treatment.
- I have the right to discuss all treatments with my provider.
- There may be a charge for late cancellations or no-show appointments.
- I am aware this consent does not include court testimony by my provider.

While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment; I realize particular results cannot be guaranteed.

Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make life changes.

If I experience a life-threatening mental health emergency, I am to contact 911 or go to my nearest emergency room. In the event of other emergencies outside of business hours, I am aware that I can contact the after hours crisis line at 1-800-247-4941.

Issues discussed with my clinician will remain confidential, *with a few exceptions.* There are some special circumstances that limit confidentiality including: a) a statement of intent to harm myself or others; b) statements indicating harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have signed a Release of Information allowing for your information to be discussed with an identified party.

I know of no reason why I should not or cannot undertake this mental health treatment and agree to participate fully and voluntarily.

Patient's Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Consent to Treatment and Confidentiality Statement. I may obtain a current copy upon request. I am aware this authorization to treat does not include court testimony by my provider. I understand that Catalyst Behavioral Health (CBH) has the right to change the Authorization for Treatment at any time.

Acknowledgement of Receipt of Privacy Notice
I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that CBH has the right to change the Notice of Privacy Practices at any time.

Office Hours and Phone calls
Office staff is available 9am-4pm Monday through Thursday, and 9am-12pm on Friday to address any questions or concerns you have. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff or when you leave a message on our confidential voicemail.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations, and I have reviewed the CBH billing policy. I have been advised that there will be a $50.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from the clinic. Exceptions to this policy are solely based on Dr. List's discretion.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review Dr. List's billing policy. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. A return check fee will be applied to my account in the case of a returned check. Electronic payment is offered as an option and includes a $5 convenience fee. To avoid paying this additional fee, please use cash or check made payable to Dr. Tracy List. A 1.33% finance charge will accrue on any unpaid balances that are 90 days or more past due. I understand Dr. Tracy List does offer financial assistance in the form of payment plans. Uninsured clients, or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Dr. Tracy List does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit card at the time of their first initial session for the office to keep in their electronic file.** Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. I understand that is no payment is received within 30 days, a payment will be automatically charged to my credit card on file. Cards will not be charged without prior notification, and opportunity to provide alternate payment will be offered at that time. Billing policies may be updated or modified throughout the calendar year. Please direct any questions about insurance, billing, and payment plans to Gina Pashby, our office manager.

Account Number: _____

Expiration Date: _____

Security Code: _____

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

Creating Positive Change

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	