

# 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) 758-0698

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 out 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:

**Klonopin / Clonazepam**  
**Ativan / Lorazepam**  
**Diazepam / Valium**  
**Alprazolam / Xanax**

### **CLINICAL OPINION POLICY**

CRMHS will not render clinical opinion on any matter related to competence, custody and/or visitation, guardianship, 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  
Subsidiary of Crossroads Community, Inc.

Corsica River Mental Health Services (CRMHS) is pleased to introduce our patient portal powered by Omedix. It is secure and user-friendly and makes communication with our practice easier than ever.

#### What can you do in the patient portal?

- Send Us Secure Messages
- View Your Health Information
- Request appointments via secure message
- Request prescription Refills via secure message
- Ask questions about your bill via secure message

...and more!

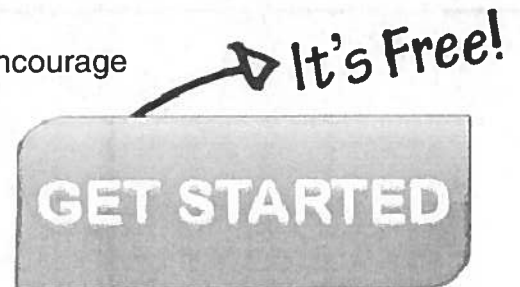
#### Why use a patient portal?

At CRMHS, we strive to provide you the best possible experience. It is our hope that the patient portal will not only make your interactions with our practice more convenient, but that it will make your experience with our practice more satisfying.

#### Get started today!

Setting up your account takes less than one minute! We encourage you to create your account to see for yourself how easy it is to use, and just how much you can accomplish online with our practice. To create an account go to <http://crmhsinc.omedixpatientportal.com/login/>.

Complete the information by clicking on creating a new account. Once approved by our office you will be all set to begin using!



Corsica River Mental Health Services, Inc.  
ADULT--Client Information / Referral Form

Date: \_\_\_\_\_

PLEASE PRINT CLEARLY

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: \_\_\_\_\_

Allergies: \_\_\_\_\_ E-Mail Address \_\_\_\_\_

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Employed: Full Time Part Time Not Employed

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouses Employer (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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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: \_\_\_\_\_

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Primary Emergency Contact

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #: (home/cell) \_\_\_\_\_ (work) \_\_\_\_\_ Relationship: \_\_\_\_\_

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: \_\_\_\_\_

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**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?  
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 \_\_\_\_\_

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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

*Reprinted with permission from the Wisconsin Medical Journal. Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. Wisconsin Medical Journal 94:135-140, 1995.*