



Intake Form Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. Thank you!

Name _____ Preferred Name _____ Date _____

Sex assigned at birth _____ Preferred Pronouns _____

Is this an emergency or crisis situation? Yes _____ No _____

If YES, please STOP completing the form and ask to speak with someone.

What services are you looking for?

Psychiatry care	Primary care	Case Management
Psychotherapy	Substance Use Counselor	Other _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

How do you think the identified services can help?

Reason for seeking services now?

Referred by? _____

Are you currently receiving care by a Physician or Psychiatrist? (Outside Ritter Center) Yes _____ No _____

If YES, please provide Provider's name, location, and phone number:

Any recent hospitalization? Yes _____ No _____ why were you hospitalized?

Current Therapist/Counselor? Yes _____ No _____

If YES, please provide therapist/counselor's name, location, and phone number:

Previous diagnosis: _____

List of previous or current medications: _____

Check substances you currently use? Meth crack cocaine alcohol

marijuana Hallucinogenics caffeine cigarettes Nicotine-vape heroin fentanyl

other _____



New Patient Registration Form

TODAY'S DATE: _____

Last Name	First Name	MI	Date of Birth
Street Address:			
City:	State:	ZIP CODE (required field)	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Transgender Female (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Choose Not to disclose	Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose		
Email:	Phone number: () - Okay to leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Security Number: _____ - _____ - _____	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living with partner <input type="checkbox"/> Widower	Preferred Communication: <input type="checkbox"/> Verbal <input type="checkbox"/> Written <input type="checkbox"/> Sign Language		
Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Language:		
Race (check all that apply): <input type="checkbox"/> Caucasian/white <input type="checkbox"/> American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Decline to Say	Housing Status: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless If Homeless: <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Other <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Street or Car <input type="checkbox"/> Staying temporarily with Friends/Relatives <input type="checkbox"/> Public Housing		
Employment Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired Migratory/Seasonal Agricultural Workers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired	Student: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Emergency Contact Name	Relationship to Patient	Phone Number
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Patient Insurance

Insurance: <input type="checkbox"/> None <input type="checkbox"/> Medi-cal <input type="checkbox"/> Medicare <input type="checkbox"/> Other	
Primary Insurance: _____	Subscriber ID: _____
Do you want Ritter Health Center to be your Primary Care Doctor? <input type="checkbox"/> yes <input type="checkbox"/> no	

Sign & Authorize

The information I gave on this form is true and correct to the best of my knowledge.

- I give consent for the employees at Ritter Center Health Center (RCHC) to do the medical exams, procedures, treatment, and referrals they need to care for me.
 - I agree to follow RCHC payment rules for the services I get.
 - I authorize the release of any information RCHC needs to process my medical claims.
 - I authorize the payment of any government benefits or insurance payments due to RCHC for services they give me.
- For Ritter Health Center clients: I understand that my medical and mental health records may be shared internally with Ritter Center staff and externally with other health care providers who are involved in my care, to coordinate treatment and services and help facilitate referrals.
- For Ritter Safety Net clients: I understand that my substance use treatment records will only be shared with others outside of the Ritter Center Safety Net program if I have provided authorization for such disclosure.

I give RCHC permission to review pharmacy records related to the health care I get: _____ (initial here)

(Patient Signature)

Sliding Scale Fee Application and Income Declaration Form

Ritter Health Center provides services regardless of your ability to pay. Based upon your income, a discount may be available. Ritter Center will use the information you give on this form only to see if you qualify under the Sliding Scale Program of the Federal Poverty Income Guideline. The Sliding Scale lets you pay a reduced price for some services at Ritter Center. Please include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

- 1.) Name (Please Print): _____
- 2.) What is your monthly income, before taxes are taken out? \$ _____
- 3.) What is your household's combined income? \$ _____
- 4.) Where does this income come from? (Work, disability, etc.) _____
- 5.) How many family members live with you? (count only your spouse & children) _____

I certify that the information I gave on this form is true and accurate to the best of my knowledge.

Patient Signature

Date

Client Consent for Data Collection and Release of Information

WHAT IS THE HMIS?

The HMIS is a data system that stores information about homelessness and housing services and programs. The purpose of the HMIS is for homeless provider agencies to record information about clients that they serve. This information helps the provider agencies plan for and provide services to clients and to meet requirements of funders such as the U.S. Department of Housing and Urban Development (HUD). HMIS also allows agencies to improve services that support people who are homeless by allowing authorized staff to share client information with the permission of the client. Marin County Health & Human Services manage the HMIS for Marin County.

WHAT IS THE PURPOSE OF THIS FORM?

With this form, you can give permission to have information about you collected and shared with the different Partner Agencies that provide housing and services in Marin County. A current list of Partner Agencies is at <http://marin.clarityhs.help>. At this time, the Partner Agencies include:

Adopt A Family of Marin	Marin County Health & Human Services
Buckelew	Marin Housing Authority
Downtown Streets Team	St. Vincent de Paul Society
Homeward Bound of Marin	Ritter Center
Homeless Outreach Team (HOT)	U.S. Department of Veterans Affairs (VA)
Marin Community Clinics	

BY SIGNING THIS FORM, I AUTHORIZE Marin County and Partner Agencies to share my information entered into the HMIS. The HMIS information shared will be used to help provide housing and services, which includes care coordination, counseling, food, utility assistance, and to evaluate and improve the quality of housing and service programs. I understand that the Partner Agencies may change over time and that I may find a current list at <http://marin.clarityhs.help>.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- The information to be collected and shared includes:
 - Name, birthday, gender, race, ethnicity, social security number, contact information, veteran status
 - Basic information on self-reported disabling conditions caused by medical, mental health, substance use or developmental factors, including self-reported HIV/AIDS status.
 - Housing Information
 - Employment, income, insurance and benefits information
 - Services provided by Partner Agencies
 - My answers to assessment questions, including the VI-SPDAT questionnaire
 - My photograph or other likeness (if included)
- I may refuse to provide any of this information. If I refuse, I will not lose any benefits or services.
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- Marin County and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review the privacy policies that govern this information.

- Marin County Health & Human Services and BitFocus use passwords and encryption technology to ensure that information in the system is safe, and each HMIS User and Partner Agency has signed an

agreement to maintain the security and confidentiality of HMIS data. However, there is always a small risk of a security breach, and someone might obtain my information and use it inappropriately. Marin County and Partner Agencies are required to alert me if they know of a breach.

- If I have questions about my HMIS information, my rights regarding that HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at marin@bitfocus.com.
- I can receive a copy of this Consent and the Client Information Sheet.
- This Consent will expire 3 years from my last HMIS recorded activity.
- I may revoke this Consent at any time by sending a written request to marin@bitfocus.com or by contacting the Partner Agency that is providing this Release of Information.
- My HMIS information may be shared to coordinate referral and placement for housing and services.
- My HMIS information may be further shared by the Partner Agencies to other agencies if needed for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be included in reports for auditors or funders who review the work of the Partner Agencies, including HUD, the Department of Veteran Affairs, the Marin County Department of Health and Human Services, and the California Department of Housing and Community Development. I understand that the list of auditors and funders may change over time. My identity will not be shared in these reports.
- My HMIS information may be used for research; however, my identity will remain private.

I have been offered and declined a copy of this form **OR**

I have received a copy of this form

SIGNATURE:

Date:

Printed Name:

FOR AGENCY USE ONLY:

Client Opted Out/Refused Consent: _____ (Staff/Agency Initials)

Witness Staff & Agency

Date

RITTER HEALTH CENTER
Notice of Privacy Practices – Health Care Clients

We care about protecting your private information and supporting your rights. This is our new Notice of Privacy Practices which goes into effect on September 11, 2020. We hope you find it helpful and easy to understand. Please read it carefully. If you have any questions, you can contact our Privacy Officer via email privacy@rittercenter.org and we'll be happy to speak with you!

Your Rights

When it comes to your health information, you have certain rights.

Ritter Center is committed to maintaining and protecting the confidentiality of your private health information. When we use the term health we will always mean both your physical and mental health. Ritter Center is required by federal law, including the Health Insurance Portability and Accountability Act (HIPAA) to provide you with this Privacy Notice, which describes our policies, safeguards, and practices. Whenever Ritter Center uses or discloses your protected health information, we are bound by the terms of this Privacy Notice.

This section explains your rights and some of our responsibilities to help you.

You have a right to:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Your request must be in writing. Ask us for a form.
- You can ask your staff or our Privacy Officer for any of the forms in this notice. The contact information is on the last page of this notice.
- We will provide a copy of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health information about you that you think is incorrect or incomplete.

- Your request has to be in writing. We'll give you the form and help if you need it.
- If we say "yes" and agree with your request, we will amend the information in your record.
- We may say "no" to your request, but if so, we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way. For example, you may have a different number you want us to use to leave a message, or a different address to send mail.
- We will say "yes" to all reasonable requests. If we are unable to, we'll tell you why.

Ask us to limit what we use or share

- We may use your information with other qualified professionals for treatment, payment, or our operations. You can ask us not to share certain health information for these purposes.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you directly asked us to make).

- We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Your Right to File a Complaint

- If you feel your privacy rights have been violated and wish to file a complaint, or have any questions or concerns about our privacy practices, please contact our Privacy Officer: privacy@rittercenter.org or call toll-free 888-368-4111
 - You will not be penalized for filing a complaint
 - You may also file a complaint directly with the USDH Office of Civil Rights U.S. Department of Health & Human Services Office for Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 877-696-6775 OCRMail@hhs.gov www.hhs.gov
-

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information for in the following ways:

Treatment

- For the coordination of your treatment with other health care providers who are treating you.
- This includes other health and behavioral health care staff both within and outside of Ritter Center. Example: a discussion between your primary doctor and a mental health therapist or case manager about your treatment plan.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: to bill Medi-Cal or Medicare for the cost of your health care.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
-

Ritter Center participates in system-wide health care initiatives

- **The Marin Health Gateway Health Information Exchange (HIE).** We participate in a data-sharing and integration service through a secure and confidential HIE electronic system. The HIE enables the appropriate and secure exchange of health information among HHS staff, community clinics in Marin County, Marin General Hospital, Detention Health Services, the Medi-Cal Managed Health Plan and other external partners - assisting healthcare providers and health care officials to make informed decisions, improving coordination and quality of care.
 - **You have a right to obtain a list of participating providers upon request.**
You have a right to opt out of the HIE. Just ask us how and we'll help.
 - **Redwood Community Health Center Coalition (RCHC).** We participate in an “organized health arrangement” with RCHC. Through this health arrangement Ritter Center participates in utilization reviews, quality assessments and improvement activities, and payment activities.
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How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

Help to prevent harm to yourself or others

We can disclose your information to reasonably lessen the risk of harm if we believe you present a serious and imminent threat to your own health or safety, or there's a danger to someone else, or to the public.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

Do research

- We can use or share your information to qualified personnel for health research (for example, comparing treatment outcomes of patients who received one type of treatment to those who received another) or for an audit or program evaluation.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
 - We must follow the duties and privacy practices described in this notice and give you a copy of it.
 - We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
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Our Privacy Officer

You can get more information about your rights, obtain forms, and get assistance with any of your privacy rights or questions by contacting our Privacy Officer: privacy@rittercenter.org or call toll-free: 888-368-4111

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. If Ritter Center makes significant changes, you will be informed of the new Notice and offered a copy on your next visit for treatment. The new Notice will be posted on the Ritter Center website.

The privacy practices listed in this Notice are effective September 11, 2020.

Acknowledgement of Receipt of the Ritter Center Notice of Privacy Practices by Health Care Patients

I acknowledge that I have received and reviewed the Ritter Center Notice of Privacy Practices

Name/DOB: _____ / _____ Date: _____



Advance Directive

TODAY'S DATE: _____

Last Name:	First Name:	MI:	Date of Birth:
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Do you have an advance directive or power of attorney for healthcare?

YES _____ NO _____

Would you like more information?

YES _____ NO _____

Information given

Patient Signature

Date



Consent for Treatment

I have chosen to receive behavioral health services in the form of psychotherapy or psychiatry for myself from the Ritter Center. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan and/or medication interventions which have been indicated. I understand that consistent attendance and medication adherence is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Limits on Confidentiality

Your mental health treatment records and what you say in therapy will be kept confidential except for the following exceptions:

- Mental Health and Drug and Alcohol treatment records will be integrated with my Ritter Health Center medical records for purposes of providing comprehensive treatment.
- Professional consultation with Ritter Center staff to promote client goals and success in behavioral health services.
- If your records are requested by a court order, we will make every effort to notify you if this occurs.
- With qualified personnel for audit, insurance billing and/or program evaluation purposes.
- We are required by law to report to appropriate governmental agencies suspected child abuse, elder abuse or the abuse of a dependent adult.



- If you are a danger to yourself or others, we may need to break confidentiality to maintain safety; this could include but is not limited to calling the hospital, the police and/or the intended victim.

Expectations of you as a Patient:

1. Attend your sessions on time.
2. If you cannot attend please call and reschedule your appointment 24 hrs. in advance
3. If you miss 2 appointments in a row without cancelling you will be provided a verbal warning. After 3 missed session you will be removed from the schedule.

Emergencies

I understand I may reach my Ritter Center provider at 415-457-8182. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency situation, I may call 911 or the Marin County Crisis line at (415) 473-6666.

I have read, discussed, understood, and agree to all of the above.

Signature

Date



CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES

I, _____, have been asked to receive psychotherapy/psychiatry through the telehealth system. I understand the use of the video conferencing equipment is a method of behavioral health care delivery in which services are delivered to an individual by a provider at a site other than where the individual is located. I understand that I will be receiving behavioral health services through the telehealth system. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that I will communicate through the telehealth system with a behavioral health provider located at another location. I understand there are no additional charges or fees for clinical services I will receive through the use of the telehealth system. I understand my participation in telehealth is voluntary and I may refuse to participate or decide to stop participation at any time. I have been informed of the potential consequences of my refusal to participate or stop participation in telehealth services.

I understand that my privacy and confidentiality will be protected. I also understand communication through the telehealth system occurs over secure telecommunication lines dedicated for this purpose. I understand that the likelihood of videoconferencing being intercepted by an outsider is similar to the potential interception of a phone call. I understand no video or audio recording of the service(s) will be made. When I am receiving services through the telehealth system, I understand that I will be notified as to who is in the room at the remote site.

I understand that the behavioral health providers at both my location (if applicable) and the remote video/audio site may have access to any relevant information about me including my medical records.

I have read this document and I hereby consent to participate in receiving substance use treatment services through the telehealth system under the terms described above. I understand this document will become part of my clinical record.

Please check the appropriate box below:

- I agree to participate and receive behavioral health services through the telehealth system.
- I have chosen not to participate in the telehealth system.

Client Signature

Date



Consent to Use FreedAI Scribe for Mental Health and Medical Services

Client/Patient Name: _____

Date: _____

1. Purpose of Consent

This form is to obtain your informed consent to use **FreedAI Scribe**, an AI-powered documentation tool, during your medical and/or mental health sessions. FreedAI Scribe helps providers by transcribing, summarizing, and organizing clinical notes securely and efficiently.

2. Privacy and Confidentiality

- Your privacy is a top priority. FreedAI Scribe and your provider will handle your information with strict confidentiality.
- Only authorized personnel will have access to any notes generated using FreedAI Scribe.

3. Use and Storage of Information

- FreedAI Scribe's secure systems may process the audio and/or transcriptions.
- No recordings or transcriptions will be stored permanently. Recordings are transcribed and deleted within 1-2 minutes following the appointment.
- FreedAI Scribe is designed to comply with applicable data privacy regulations, including HIPAA.

4. Benefits

- Improved accuracy and efficiency in documentation
- Enhanced continuity and quality of care (Provider can focus on you)

5. Risks and Limitations

- As with any technology, there is a minimal risk of data breach or error, although FreedAI Scribe employs industry-standard encryption and security measures.

6. Your Rights

- You may decline or withdraw your consent to the use of FreedAI Scribe at any time without affecting your access to care.

Consent

- I have read and understood the information above.
- I have had the opportunity to ask questions, and they were answered to my satisfaction.
- I voluntarily consent to the use of FreedAI Scribe during my mental health and/or medical appointments.

Signature of Client/Patient: _____

Date: _____

Ritter Center's Code of Conduct

Welcome to Ritter Center. This is your community; together we work to ensure a safe and clean place for everyone!

Our services include: health care, behavioral health, case management, food pantry, laundry, emergency financial assistance and mail. We provide these services free of charge when allowed by government regulations. In return, we expect everyone to be respectful and responsible near and in our facilities. **Ritter has a zero-tolerance policy for aggressive behavior directed by clients or patients against anyone.**

By signing at the bottom of this document, I confirm that I have read the recommended behaviors below and will comply with this Code of Conduct.

Things I **will do** to keep the Ritter Center clean and safe:

- treat all staff, volunteers, clients, neighbors and the public with respect, courtesy and according to all local, state and federal laws
- wear shoes, shirt and pants at all times
- keep my children within arm's length of me at all times
- keep my pets on a leash and assure that they are supervised while conducting my business
- lock my bicycle to the provided bike racks and remove it before Ritter closes for the day
- Park in designated and legal areas, rather than blocking driveways or parking in neighbors' lots
- leave the premises when asked by staff if they suspect any inappropriate behavior or conduct

Things I **will NOT do** because they are prohibited:

- make verbal threats of violence or use racial slurs, cultural slurs, derogatory or offensive remarks toward anyone
- physically assault, threaten to inflict bodily harm, intimidate or harass anyone
- make menacing or derogatory gestures
- bring any weapons, drugs or alcohol onto the property
- sell or share drugs or alcohol near or on the property
- steal anything from anyone on or near our facility, or from our neighbors
- threaten to or actually damage Ritter equipment or property, or that of our neighbors
- smoke near or onsite the Ritter Center or its neighbors' properties
- be on Ritter Center property after hours, on weekends or holidays

Thank you for your cooperation and assistance to keep Ritter a safe place for everyone. Anyone who violates Ritter's Code of Conduct is subject to removal from the facility and/or discharge from services.

I fully understand this agreement and I agree to abide by these rules. I understand that upon request I may receive a copy of this agreement.

Full Name: _____

Date: _____

Signature: _____

Last Revised 8/03/21