MATHIESEN MEMORIAL HEALTH CLINIC

"Close to home…far from ordinary"

Welcome to Mathiesen Memorial Health Clinic!

Mission: To improve the health and wellness of our community as the premier place to give and receive care that embraces the balance of mind, body, and spirit.

Vision: Established by the Chicken Ranch Rancheria of Me-Wuk Indians of California, Mathiesen Memorial Health Clinic is close to home, yet far from ordinary. We serve with kindness, integrity, compassion, collaboration, and strive for excellence to maximize individual and community health and wellness.

Locations:

Main Clinic

We take pride in having a happy, well-trained and courteous staff. These are just a few of the services we offer; please feel free to contact us with any medical concerns you may have.

Services: Routine Office Visits, Women's Health, Family Planning, Pediatric Care, Dermatology**, Hepatitis C Treatment**, Comprehensive Liver Care, Diabetic Treatment, Smoking Cessation Treatment, and lab draws & interpretation. (**referral required)

18144 Seco Street Jamestown, CA 95327 Phone: (209) 984-4820 Fax: (209) 984-4825

Red Feather Clinic

Serving our community to prevent and heal addiction. No referral needed, walk-ins welcome!

Services: Medication Assisted Treatment for Substance Use Disorder, Substance Use Disorder Counseling, Acupuncture Therapy, Pain Management**, Care Coordination, and NARCAN Available. (**referral required)

18232 Smoke Street Jamestown, CA 95327 Phone: (209)782-8625 Fax: (209)984-9240

Wellness Center

Our Wellness Center uses an integrative approach that helps patients to heal by taking the entire life experience into consideration.

Services: Individual, Family, and Child therapy, along with Therapeutic Yoga (virtual), Hypnosis, EMDR, Art therapy, and Psychological testing.

18158 Main St. Jamestown Ca 95327 Phone: (209)782-6446 Fax: (209)984-9169

Same Day Walk In Clinic

We provide treatment for illnesses and injuries that do not require a visit to the emergency room but need timely attention. Same day appointments available. Walk-in's welcomed!

Services: COVID testing/treatment site, Ear & Sinus Infections, Sports Physicals, Cough/Cold & Flu Symptoms, Urinary Tract Infections, Pink Eye, Rashes, Minor Sprains, STD Screening, and other non-life-threatening conditions or illnesses.

18268 Main St. Jamestown , CA 95327 Phone: (209)630-2772 Fax: (209)984-9085

Dental Clinic

Here to serve and support our community's dental needs. We offer services to all and accept Medi-Cal, Humana, out-of-network insurance, and offer a cash pay discount for the non-insured.

Services: Cleanings, Exams, Fillings, Simple Extractions, Root Canals, Crowns & Bridges, Dentures & Partials, and Digital X-rays & Impressions.

940 Sylva Lane #K2 Sonora, CA 95370 Phone: (209)536-8600 Fax: (209)536-8606

MATHIESEN MEMORIAL HEALTH CLINIC

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Therapeutic Agreement

Welcome to the Mathiesen Memorial Wellness Center!

We are honored and pleased that you have chosen our team to help you navigate life's ups and downs. Please read over the following information and fill out all forms so that we can better understand your needs. We look forward to collaborating with you soon.

Services Provided

Mathiesen Memorial Wellness Center offers outpatient behavioral health services to children, adolescents, and adults. Our services include in-person, telephone, and video appointments for individuals, couples, and family psychotherapy. Our therapists are trained in a variety of interventions, including EMDR, hypnosis, cognitive-behavioral therapy, dialectical behavior therapy, and trauma-informed practices.

Office Location and Contact Information

Office location:	Mailing address:	Phone and fax numbers:
18158 Main Street	PO Box 535	Phone: 209-782-6446
Jamestown, CA 95327	Jamestown, CA 95327	Fax: 209-984-9169

Hours of Operation

Mathiesen Memorial Wellness Center is open Monday through Friday 8:00am-12:00pm and 1:00pm-5:00pm. We are closed during all national holidays.

After Hours

Any messages left after hours will be returned during the next business day.

~In the middle of difficulty lies opportunity~

-Albert Einstein

Emergencies

In case of an emergency please refer to one of the following:

- Call 911 Emergency Services
- Call 988 Suicide and Crisis Lifeline
- The nearest emergency room (Adventist Health; Mark Twain Hospital)
- Tuolumne County Behavioral Health at 209-533-7000

Confidentiality

By law, therapists are expected to keep session content confidential. That information may only be released to designated parties by written authorization of patients or legal guardians. However, you must be informed that there are certain exceptions and limitations to confidentiality. These limitations generally concern the safety and well-being of patients and significant others. Exceptions to confidentiality are as follows:

1. Therapists are **mandated reporters** and as such **required by law** to report a *reasonable suspicion* of abuse or severe neglect of children (under 18 years of age), dependent adults, and elders (65 and older) to appropriate authorities. The purpose of the reporting requirement is the protection of our most vulnerable members of society.

2. Therapists are legally and ethically required to act to maintain safety in dangerous situations, particularly imminent threat of suicidality, homicidality, or destruction of property that could endanger others. An imminent threat is a disclosure of serious *intentions*. "Intentions" means not only a desire to act, but also a plan of how to act, the means to carry out the plan, and an imminent timeline. It *does not* include patient fantasies, desires, or wishful thinking. The therapist may have to break confidentiality by notifying a patient's family members or friends, co-workers, employers, intended victims, and/or law enforcement to ensure safety.

3. If patients introduce their mental status into legal proceedings, the court could subpoena their records. Additionally, if a patient is involved in a legal proceeding (divorce, custody dispute), therapist records could be subpoenaed. If the therapist receives a court order to release information, the therapist must comply. In some cases, the court is satisfied with a summary of patient records.

Record Keeping

All patient records will be completed and retained according to State and Federal regulations, standards of practice, and in keeping with the policies and procedures set forth by Mathiesen Memorial Health Clinic.

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Records Release

An authorization to release records will need to be completed in full, signed, and on file before records may be released. The treating provider will discuss the request for release with the patient and/or guardians involved and will use discretion regarding appropriate release of information.

Patient Rights

Mathiesen Memorial Wellness Center will adhere to the patient's rights as established by Mathiesen Memorial Health Clinic (available upon request.)

Provider Rights

Providers have the right to discontinue services at any time as appropriate. Some circumstances that may lead to discontinuation of services include, but are not limited to, when a provider determines that: services are no longer beneficial, a patient is not compliant or appropriately investing in treatment, a patient has behaved in an unsafe or disrespectful manner to staff and/or other patients, a patient has exceeded the number of no-shows and/or cancellations allowable, or if a patient has failed to make expected payment for services. If services are discontinued, patients will be offered mental health referrals and resources as appropriate.

No Shows and Cancellations

Mathiesen Memorial Wellness Center will adhere to the no-show and cancellation policy as established by Mathiesen Memorial Health Clinic (available upon request.)

Risks and Benefits

There are risks and benefits to participating in Behavioral Health services. The risks may include an increase in symptoms or distress while issues are explored and discussed. However, benefits may include a reduction or absence in symptoms as treatment progresses. Such a decrease in symptoms may lead to resolution of issues, improvement in quality of life, relationships, and daily functioning.

Consent for Treatment

By signing this agreement, I authorize and consent to treatment services provided by the Mathiesen Memorial Wellness Center.

Consent for Telemedicine

By signing this agreement, I authorize and consent to telemedicine treatment services provided by the Mathiesen Memorial Wellness Center. I am aware of the benefits/risks of phone and video telehealth.

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Consent for Collaboration

By signing this agreement, I authorize the Mathiesen Memorial Wellness Center to collaborate with Mathiesen Memorial Health Clinic staff and other relevant medical and behavioral health professionals to discuss treatment plans as indicated.

Consent for Contact

By signing this agreement, I authorize Mathiesen Memorial Wellness Center to utilize the contact information on file to leave messages as well as to send correspondence.

Consent for Insurance Billing

By signing this agreement, I authorize the release of relevant mental health information, such as diagnosis and treatment, for the purpose of insurance billing.

Understanding

By signing this agreement, I am demonstrating that I have read and understand the above stated. If I have any further questions or concerns, I will discuss them with my provider and/or relevant administrative staff.

Patient Signature

By signing this form, I am acknowledging receipt of the Mathiesen Memorial Wellness Center Therapeutic Agreement.

_____

Patient Name

_____ _____

Signature of Patient or Parent/Gaurdian Date

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Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ Date of Birth:_____/_____/_____

Gender: ☐ M ☐ F ☐ M to F ☐ F to M ☐other Race: _____ Marital Status: _____

Social Security # (SSN): _____ Email Address: _____

Home Phone #: ( )_____ - _____ Cell Phone #: ( )_____ - _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Tribal Affiliation: _____

Mailing Address:

Address: _____ City: _____ State: _____ Zip: _____

Physical address (if different from mailing address*)*:

Address: _____ City: _____ State: _____ Zip: _____

Guarantor Information (Complete ONLY if patient is a minor**):**

Parent/Guardian Name: _____ Relationship: _____ Date of Birth:_____/_____/_____

Phone #: ( )_____ - _____

Insurance Information:

Primary Insurance: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: ____/____/____ Group #: _____

Secondary Insurance: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: ____/____/____ Group #: _____

Prescription Coverage: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: ____/____/____ Group #: _____

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Patient History Questionnaire

Name of Patient: _____

Name of Parent/Legal Guardian: _____

Date of Birth: _____/_____/_____

Service Interest:

- ☐ Psychiatric/Psychopharmacology
- ☐ Individual Psychotherapy
- ☐ Couples or Family Therapy

What are the main reasons you are seeking therapy now?

_____

_____

_____

_____

Current Symptoms: Please check **all** that apply

☐ Distractibility	☐ Lack of motivation	☐ Racing thoughts
☐ Hyperactivity	☐ Withdrawal from people	☐ Excessive energy
☐ Impulsivity	☐ Anxiety/worry	☐ Mood swings
☐ Boredom	☐ Panic attacks	☐ Sleep Problems
☐ Poor memory/confusion	☐ Fear away from home	☐ Nightmares
☐ Seasonal mood changes	☐ Social discomfort	☐ Eating problems
☐ Sadness	☐ Obsessive thoughts	☐ Gambling problems
☐ Loss of pleasure/interest	☐ Compulsive behavior	☐ Computer addiction
☐ Hopelessness	☐ Aggression/fighting	☐ Problems with pornography
☐ Thoughts of death	☐ Frequent arguments	☐ Parenting problems
☐ Self-harm behaviors	☐ Irritability/anger	☐ Sexual problems
☐ Crying spells	☐ Homicidal thoughts	☐ Relationship problems
☐ Loneliness	☐ Flashbacks	☐ Work/school problems
☐ Low self esteem	☐ Hearing voices	☐ Alcohol/drug use
☐ Guilt/shame	☐ Visual hallucinations	☐ Recurring, disturbing memories
☐ Fatigue	☐ Suspicion/paranoia	☐ Change in appetite

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Please list any other current symptoms/concerns not listed above:

_____

_____

_____

Mental Health Treatment History: Please check **all** that apply and briefly describe

- ☐ Previous counseling/therapy
- ☐ Previous/current psychiatric medication
- ☐ Previous psychiatric/mental health diagnoses
- ☐ Previous psychiatric evaluation or hospitalization
- ☐ Previous psychological evaluation
- ☐ Family history of psychiatric issues

Please briefly describe:

_____

_____

_____

_____

Medical History:

- ☐ Acid Reflux/GERD
- ☐ Alcohol/drug use disorder
- ☐ Allergy problems
- ☐ Anemia
- ☐ Anticoagulation therapy
- ☐ Anxiety
- ☐ Artery/Vein problems
- ☐ Arthritis/Joint problems
- ☐ Asthma
- ☐ Autoimmune Disease
  Specify:_____
- ☐ Blood Clots
  Location:_____
- ☐ Bleeding problems
- ☐ Cancer
  Specify:_____
- ☐ Cataracts
- ☐ C. Difficile
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ COPD
- ☐ Chronic Pain
  Specify:_____
- ☐ Delay in meeting developmental milestones
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Esophagitis, Ulcers
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gallstone
- ☐ Glaucoma
- ☐ Head injury
- ☐ Heart Disease
  Specify:_____
- ☐ Heart valve problems
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
  Specify:_____
- ☐ Lung Disease
- ☐ Pancreatitis
- ☐ Primary Biliary Cholangitis
- ☐ Migraines
- ☐ Mental health diagnosis
- ☐ MRSA
- ☐ Prostate problems
- ☐ Psoriasis
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infection
- ☐ Sleep Apnea
- ☐ Stroke/CVA
- ☐ TB
- ☐ Thyroid diseases
- ☐ Ulcerative Colitis

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Medication List:

Please list ***all prescription*** and ***non-prescription*** medications. This includes vitamins, herbal medicine, supplements, birth control pills, inhalers and over-the-counter medications.

Medication	Dosage	How often	Disease/Reason	Prescribed by

Preferred Pharmacy: _____

Secondary Pharmacy / Mail Order: _____

Allergies or reactions:

Medication/Food/Environmental	Reaction	Medication/Food/Environmental	Reaction
1.		4.	
2.		5.	
3.		6.	

Current Living Arrangements: Please check **all** that apply and describe below

- ☐ Others living in the home
- ☐ Difficulties at home
- ☐ Strained relationships in the home
- ☐ Significant relationship

_____

_____

_____

_____

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Nutrition: Please check **all** that apply and describe below

- ☐ Current Concerns
- ☐ Difficulty regarding nutritional choices
- ☐ Difficulty with food availability

_____

_____

_____

Trauma History: Please summarize below any significant trauma history

_____

_____

_____

_____

"Your resilience shines brighter than any darkness you've faced"

Social Functioning: Please check **all** that apply and describe below

- ☐ Current support system
- ☐ Able to establish and maintain relationships
- ☐ Concerns related to relationships
- ☐ Concerns related to social functioning

_____

_____

_____

Substance Use: Please check **all** that apply and describe below

- ☐ History of abuse and/or addiction
- ☐ Current use of alcohol and/or drugs
- ☐ Substance use treatment history

_____

_____

_____

Educational History: Please check **all** that apply and describe below

- ☐ Graduated 8th grade
- ☐ Graduated high school or equivalency
- ☐ Some college
- ☐ Undergraduate college degree
- ☐ Graduate degree

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Employment Status: Please describe

_____

_____

_____

Legal History: Please check **all** that apply and describe below

- ☐ Past legal involvement
- ☐ Present legal involvement
- ☐ Past or present involvement in family court

_____

_____

_____

Activities of Daily Living: Please check **all** that apply and describe below

- ☐ Sleep disruption
- ☐ Appetite disruption
- ☐ Energy level disruption
- ☐ Difficulty completing daily tasks or chores
- ☐ Difficulty engaging in hobbies/activities

Strengths/Resources/Support: Please describe

_____

_____

_____

_____

_____

_____

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CONSENT TO TREAT

I, the undersigned, am requesting health care services from the personnel at Mathiesen Memorial Health Clinic. I consent to exams, tests, immunizations, and treatment deemed necessary for my health. I hereby authorize the release of any information, including diagnosis of medical condition, for the purpose of payment by my insurance carrier. I affirm that the statements are true and correct to the best of my knowledge. I authorize the release of any information required by my insurance company to process claims. I further authorize assignment of benefits directly to Mathiesen Memorial Health Clinic. I understand that in the event the insurance information is not complete and correct, or if my insurance fails to make payment, I will be financially responsible for services rendered.

_____ ____/____/____

Printed Name Date of Birth

_____ ____/____/____

Signature of Patient/Parent/Guardian Date

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NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic (MMHC). Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by asking for one at the clinic or contacting our Privacy Officer at 209-984-4827.

If you have any questions about our Notice of Privacy Practice, please contact:

Privacy Officer
P.O. Box 535
Jamestown, Ca 95327
Phone: 209-984-4827

I acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic.

Patient Name : _____

Patient Signature : _____ Date : _____

MATHIESEN MEMORIAL HEALTH CLINIC

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Missed Appointment Policy

Patient Name: _____ Date of Birth:

Thank you for choosing Mathiesen Memorial Health Clinic (MMHC) as your health care provider. To ensure the highest quality of care for you and all our patients, we ask that you adhere to our guidelines concerning missed appointments. MMHC provides appointment reminders as a courtesy, but we kindly ask that you take responsibility for keeping or canceling it as needed. We require at least 24-hour notice to cancel or reschedule your appointment. This allows us to offer your cancelled appointment slot to another patient in need of care.

While MMHC strives to minimize missed appointments, we will allow up to three missed appointments in a six-month period. An appointment is considered missed under any of the following circumstances:

- Patient fails to show up to a scheduled appointment.
- Patient provides fewer than 24 hours' notice to cancel or reschedule an appointment.
- Patient who arrives more than 10 minutes past their scheduled appointment time.
  **For dermatology and same-day appointments, the grace period is reduced to 5 minutes*.
- Wellness Center:
  - New patient – grace period is 15 minutes
  - Established patients – grace period is 30 minutes

Patients who miss three of more consecutive appointments within a rolling six-month period may be dismissed from care at the clinic's discretion.

_____ _____

Signature Date

_____

Printed Name

Relationship to Patient (if applicable): _____

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PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Do you give our office permission to discuss your medical and/or financial information with a person(s)?

☒ Yes ☐ No (If yes, please provide additional information below)

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

May we leave personal medical information on your answering machine, voicemail, email, or text message: ☐ Yes ☒ No

Patient Name: _____ Date of Birth:

Patient Signature: _____ Date:

Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why it was not obtained. Patient reason for refusing or inability to sign acknowledgement:

_____

Staff Use- Clinic accepting Patient Authorization form:

☐ Primary Care
☐ Dental Clinic
☐ Walk-In Clinic
☐ Red Feather Clinic
☐ Wellness Center
☐ Acupuncture

Patient Label