BEHAVIORAL HEALTH INTAKE FORM – CHILD/ADOLESCENT

Patient name: _____ **Preferred name:** _____

Patient date of birth: _____

Parent/guardian name(s): _____

How were you referred to this service?: ☐ Self ☐ Family ☐ School ☐ Physician ☐ Court ☐ Other: _____

What are your concerns about your child at this time? Please check all that apply:

☐ inattention
☐ forgetful
☐ learning difficulties
☐ noncompliant
☐ sad
☐ mood swings
☐ breaking property
☐ hyperactive
☐ angry
☐ aggressive outbursts
☐ speech problems
☐ odd behaviors
☐ fearful or timid
☐ stomachaches
☐ holds pee or poop
☐ pees or poops on floor or furniture
☐ wets the bed
☐ stealing
☐ alcohol or drug use
☐ fighting
☐ separation anxiety
☐ difficulty sleeping
☐ eating too much or too little
☐ repetitive behaviors
☐ parent-child conflict
☐ school suspensions
☐ few or no friends
☐ substance use

Other concerns about your child: _____

_____

_____

Has your child received a mental health diagnosis in the past?: ☐ Yes ☐ No

If yes, what diagnosis did they receive?: _____

Has your child received therapy before?: ☐ Yes ☐ No

If yes, when and where?: _____

What would you like to get out of therapy?: _____

Are you willing to participate in your child's therapy sessions?: ☐ Yes ☐ No

Has your child ever been hospitalized for mental health reasons?: ☐ Yes ☐ No

If yes, when and where?: _____

Do they take any medications?: ☐ Yes ☐ No

If yes, type and dosage?: _____

Does your child have a history of trauma/abuse (emotional, verbal, sexual, physical, or neglect)?: ☐ Yes ☐ No

How long have you (or someone you trust) been concerned about your child?: _____

Does your child have any involvement with any of the following people or services?:

☐ Day Treatment ☐ Case Management ☐ Probation ☐ Child Protection ☐ Guardian Ad Litem

Does your child have any medical concerns?: ☐Yes ☐No
If yes, please explain: _____

Does your child have a history of a developmental delay?: ☐Yes ☐No

Name of school: _____ **Grade:** _____

Special education services?: ☐Yes ☐No

Individualized Education Plan (IEP)?: ☐Yes ☐No

Academic concerns?: ☐Yes ☐No

Behavioral concerns (at school)?: ☐Yes ☐No

History of foster care placement(s)?: ☐Yes ☐No

How many times have you moved in the last two years?: ____ times

Is there anything else you would like us to know?: _____

_____

_____

_____

_____

_____

_____

Signed (Parent/Guardian): _____ Date: _____

Form completed by: _____ Relationship to patient: _____

BEHAVIORAL HEALTH APPOINTMENT POLICIES

Please read the following behavioral health appointment policies:

1) Please arrive to the clinic 10-15 minutes before your scheduled appointment in order to allow time for check-in, to provide current insurance information, and complete any other necessary paperwork.
2) If you know you will not be able to make your appointment, we ask that you **call the clinic at least 24 hours in advance**. Failure to call in advance may affect future scheduling.
3) If you no-show/late cancel (less than 24-hour notice) three times consecutively, you may be asked to be put back on the waitlist for services.
4) If you are late for your appointment, we may not be able to see you and we may need to reschedule or we may have a shortened appointment.
5) If you need any paperwork to be completed by your behavioral health provider (e.g., medical opinion form, referral for case management, etc.) it could take **up to 3 sessions** for the provider to be knowledgeable about your health needs in order to complete the paperwork. Please allow time for providers to complete these requests. Requests for immediate help with applications may be delayed until a later date.

Signing below acknowledges your understanding and consent to the policy stated above:

Patient Name (Printed): _____

Signature of Patient/Guardian: _____ Date: _____

PATIENT RIGHTS & RESPONSIBILITIES

Behavioral health services are provided by professionally trained staff who are dedicated to the right and civil liberties of all patients. We strive to provide respectful, culturally competent, and comprehensive care within Open Cities Health Center for each person. We encourage people to be fully involved in their care.

Patient Rights:

1. To receive respectful, appropriate, and competent professional service.
2. To determine what information you will share and to participate in the development of your treatment plan, including the frequency and duration of services.
3. To be aware of the policies and procedures regarding behavioral health services at Open Cities Health Center and to receive whatever information you need to understand your experience.
4. To know that the information you share will be held in confidence and will not be disclosed outside Open Cities Health Center without your informed written consent. Exceptions to this policy include the following:
    a. When a court of competent jurisdiction orders release of the records;
    b. When there is knowledge of, or a reasonable cause to believe a minor or vulnerable adult is being neglected, physically, or sexually abused;
    c. When it is believed there is a serious, foreseeable, and imminent danger of physical harms or violence to the patient or other identified persons/society.
5. To know that your medical information is stored in the Open Cities Health Center electronic health record, managed by the medical records department.
    a. To provide care that is informed by knowledge of the whole person, all OCHC providers have access to all documentation of patient care.
    b. Any employee who does not need to know the details about your care is either blocked from accessing that part of the record or trained to respect every aspect of your privacy. If an unauthorized employee violated any aspect of your privacy they could be subject to termination.
    c. You may ask that your behavioral health notes be locked. No other employees will have access.
6. To receive notification, as soon as possible, when an appointment with your provider must be cancelled.
7. To issue a complaint and pursue a grievance procedure by contacting a supervisor.

Patient Responsibilities:

1. To be open and straightforward about concerns and circumstances that bring you to behavioral health services.
2. To give Open Cities Health Center staff reasonable notice when an appointment cannot be kept.
3. To keep current in paying your fees at the time of service unless other arrangements have been made with the billing department.
4. To notify the billing department of any income changes so that your fee(s) can be adjusted accordingly.
5. To be aware of the out-of-pocket cost for behavioral health services –
   Diagnostic Assessment/Mental Health Intake - **$259.00** without insurance/sliding fee application
   Individual/Family/Couples Psychotherapy Session - **$195.00** without insurance/sliding fee application
   Psychological Testing - **price varies depending on needed services, multiple appointments are generally required*
   ARMHS - **price varies depending on needed services*
6. To be aware that any unscheduled sessions will be billed at the regular session rate, with or without insurance/sliding fee application.
7. To complete a survey, when requested, to evaluate the extent to which you were satisfied with the services at Open Cities Health Center and any outcomes/setbacks you may have experienced.

I have read my rights and responsibilities, and I understand them. If at any time I have questions, I know that I may ask for clarification.

_____	_____	_____
Patient Printed Name	Patient/Guardian Signature	Date

INFORMED CONSENT FOR TELEHEALTH SERVICES

Telehealth involves the use of electronic communication through telephone call or videoconferencing to enable patients to have access to health care providers who are at a different location for the purpose of improving patient care. Electronic systems will incorporate network and software security to protect the confidentiality of patient information and safeguard data.

By signing this form, I understand the following:

- The laws that protect the privacy and confidentiality of medical information also applies to telehealth and no information obtained in the use of telehealth which identifies a patient will be disclosed to other entities without patient consent**.** No one will record the session without consent from both parties. Recording used for training purposes will require written consent.
- There is a right to withhold or withdraw consent to the use of telehealth in the course of care at any time without affecting future care or treatment.
- There are potential benefits and risks of using telehealth that differ from in-person appointments that may limit the type of services that can be offered to healthcare (e.g., including insufficient video imaging/resolution, reduced audio connectivity, etc.).
- It is important to use a secure internet connection rather than public/free Wi-Fi, and to be in a quiet, private space free of distractions in a well-lit room.
- The patient will need to inform the provider of their physical address at the start of each telehealth session.
- The clinic will need a back-up plan (e.g., a phone number/email where patient can be reached) to restart the session or to reschedule it in the event of technical problems.
- Patients are strongly recommended to be seen in-person for their initial appointment and then every six months after the initial appointment.
- Telehealth services are submitted to insurance like any other health service; however, if the service is not reimbursed, the patient is responsible for full payment.
- Co-pays for telehealth sessions are collected the week following provision of services by the billing department (unless a payment plan is already established with the billing department.)
- My provider may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our appointments in-person or by other means to get healthcare needs met appropriately.

Physical address where the patient will be attending their telehealth sessions:

Address:_____ City: _____ Zip Code: _____

Patient Name (Printed): _____

Signature of Patient/Guardian: _____ Date: _____