Prime Behavioral Health, LLC

CHILD/ADOLESCENT INTAKE PACKET

Client Name _____

Street Address _____ PO Box _____

City/State/Zip _____

Home Phone # _____ **May we call or leave a message at this number?** ❑ Yes ❑ No

Daytime Phone # _____ **Can we contact you here and leave a message?** ❑ Yes ❑ No

Cell Phone # _____ **May we call or leave a message on this phone?** ❑ Yes ❑ No

Client Date of Birth _____ Age: _____Social Security # _____

Parent/Responsible Party Name (if client is minor)_____

Parent/Responsible Party Social Security # _____ Date of Birth_____

Primary Care Physician & Phone#: _____

Emergency Contact Name (required): _____ **Phone #**:_____

Address (required):_____

If we may email you, please provide your address below. *Bear in mind that email* ***IS NOT SECURE. NO PRIVATE INFORMATION OTHER THAN YOUR NAME, EMAIL ADDRESS AND/OR APPOINTMENTS WILL BE INCLUDED.***

_____@_____

Insurance Information (Copy of Insurance Card and ID is Required)

• This section is required to be filled out in full •

1) Primary Insurance Company _____Ins Co Phone # _____

Employer of Subscriber _____

Name of Subscriber _____Date of Birth _____

Subscribers Social Security # _____ Relationship to Client_____

Address of Subscriber (if different from Client) _____

2) Secondary Insurance Company _____ Ins. Co Phone # _____

Employer Name _____

Name of Subscriber _____Date of Birth _____

Subscribers Social Security # _____ ___Relationship to Client _____

Address of Subscriber (if different from Client) _____

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU ATTACHMENT

CLIENT/ RESPONSIBLE PARTY AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to PBH to release such information as may be necessary for completion of my insurance claim with payment of benefits to PBH for services rendered.

_____ _____ _____

Responsible Party Name (please print Responsible Party Signature Date

_____ _____

Witness Date

Revised 01/16

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____ Today's Date: _____

Identifying Information
Child's Name:_____ **Date of Birth:** _____ **Age:**_____ **Gender:** ❑ Male ❑Female **Race:** _____ **Height:** _____ **Weight:**_____ **Hair Color:**_____ **Eye Color:** _____

Behavioral Health
Why is the child coming to counseling?
What issues or circumstances do you believe contribute to the child's problems?
How long has this problem persisted? _____
Under what conditions do the problems usually get worse?
Under what conditions do the problems usually improve?
Has the child previously been involved in counseling? ❑No ❑ Yes **If yes, describe the reasons for counseling, who provided the counseling and what was the outcome.** **Counselor** _____ **Reason:** **Outcome:**
List your child's greatest strengths:
List your child's greatest weaknesses:
List your child's main difficulties at home:
List your child's main difficulties at school:

Psychiatric Hospitalizations: ❑ **None** ❑ **Past** ❑ **Recent**

Dates of Service:	**# of Days**	**Where & Reason (suicidal, depressed etc.)**
Dates of Service:	**# of Days**	**Where & Reason (suicidal, depressed etc.)**

Behavioral Health Symptom Checklist

Please indicate the degree your child has experienced any of the following symptoms in the last 4 weeks.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

_____ 1. Trembling, or feeling shaky
_____ 2. Shortness of breath or smothering sensation
_____ 3. Racing heart, heart palpitations or chest pain (circle which)
_____ 4. Moist palms or excessive sweating
_____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
_____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
_____ 7. Frequent headaches or other muscle aches
_____ 8. Startle easily
_____ 9. Irritability (loses temper easily)
_____ 10. Worrying a lot
_____ 11. Trouble swallowing, "lump in throat", or choking sensation
_____ 12. Fearful of or embarrassed by being watched or being the focus of attention
_____ 13. Avoid talking to strangers
_____ 14. Fear of embarrassment
_____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
_____ 16. High levels of anxiety in the presence of an object or situation
_____ 17. Regular and disturbing thoughts about a past traumatic experience
_____ 18. Regular and disturbing dreams about a past traumatic experience
_____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
_____ 20. Excessive hand washing or fear of germs
_____ 21. Excessive checking (i.e., doors, locks, stove)
_____ 22. Excessive need for order or neatness or counting ritual(s)
_____ 23. Unusual and persistent sad feelings
_____ 24. Diminished interest or participation in enjoyable or important activities
_____ 25. Difficulty concentrating or poor memory (circle which)
_____ 26. Tire easily or low energy level
_____ **27**. Thoughts of suicide
_____ 28. Increased or decreased sleep (circle which): avg. hrs per night ____
_____ 29. Feelings of hopelessness
_____ 30. Persistent and abnormally elevated mood
_____ 31. Over inflated feelings of self-worth
_____ 32. Decreased need for sleep
_____ 33. Rapid or racing thoughts
_____ 34. Excessive involvement in pleasurable activities
_____ 35. Excessive and/or reckless spending
_____ 36. See or hear things that others around you are unable to perceive
_____ 37. Hold ideas or beliefs that are not shared by others
_____ 38. Self induced vomiting
_____ 39. Excessive exercise
_____ 40. Use of laxatives or diuretics to lose weight
_____ 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
_____ 42. Careless mistakes in school work, work, or other activities
_____ 43. Can only pay attention for short periods at school/work/home
_____ 44. Failure to complete schoolwork, chores, duties
_____ 45. Hyperactive: fidgets, squirms, talks excessively
_____ 46. Acts without thinking of consequences

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	❑	❑	❑	**Hallucinogens**	❑	❑	❑
Marijuana	❑	❑	❑	**Inhalants**	❑	❑	❑
Hashish	❑	❑	❑	**Cocaine**	❑	❑	❑
Stimulants	❑	❑	❑	**Heroin**	❑	❑	❑
Sedatives	❑	❑	❑	**Other**: _____	❑	❑	❑

If current or past use is indicated to any of the above items compete the following questions?

Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method
					❑Oral ❑Smoked ❑Nasal ❑Injection
					❑Oral ❑Smoked ❑Nasal ❑Injection
					❑Oral ❑Smoked ❑Nasal ❑Injection

Has the child ever received inpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? _____ **Where?** _____

Has the child ever received outpatient drug and/or alcohol treatment? ❑ No ❑ Yes

If yes, When? _____ **Where?** _____

Is the child currently pregnant? ❑ No ❑ Yes **Is the child an IV drug user?** ❑ No ❑ Yes

Family History

Parent's marital status: ❑ Married ❑ Divorced ❑ Separated ❑ Never Married ❑ Widowed

If the parents are not married, the child's age when divorce, separation or parents death occurred? _____

What is the relationship between the child and his/her custodial parent(s) Check all that apply:

❑Parents married, together ❑Single Parent, Mother ❑Single Parent Father ❑ Parents Unmarried
❑Mother & Stepfather ❑Father & Stepmother ❑Adoptive Family
❑Other _____

Living Situation: ❑ Parent's Home ❑Foster Home ❑ Relative's Home ❑Homeless ❑Group Home
❑Residential ❑ Other _____

Household member's names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education

Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Mother's age: _____ If deceased, how old was the child when she passed away? _____

Father's age: _____ If deceased, how old was the child when he passed away? _____

Number of Brothers _____ Their ages: _____ _____ _____ _____ _____

Number of Sisters _____ Their ages: _____ _____ _____ _____ _____

Where is the child in birth order (i.e. 1st born, 2nd born etc.) of his/her siblings? _____

Briefly describe the child's relationship with his/her siblings.

Briefly describe the style of parenting (including types of discipline) used in the household.

Describe the reasons your child is disciplined.

Parent's Employment

Mother's Current Employment Status ❑Employed ❑Unemployed Job/Occupation:_____

Name of employer: _____ Date Last Worked_____ Satisfied with Job ❑Yes ❑No

Father's Current Employment Status ❑Employed ❑Unemployed Job/Occupation:_____

Name of employer: _____ Date Last Worked_____ Satisfied with Job ❑Yes ❑No

Family Financial History:

Amount of Monthly Income_____ Source(s) of income: _____

Loss of Income due to: _____

Financial Problems ❑ No ❑Yes If yes, explain: _____

Developmental History

List any drugs/medications used by the mother or family at the time of conception or by the mother during pregnancy

Indicate important physical development issues including developmental milestones including sensory/motor, motor, cognitive, mental retardation or autism

List the ages when the following developmental milestones occurred:

	Age	**Comments**
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

Rate your child's development, compared to others the same age in the following areas

Social Development	❑Below Average	❑Average	❑Above Average
Physical Development	❑Below Average	❑Average	❑Above Average
Language	❑Below Average	❑Average	❑Above Average
Intellectual Ability	❑Below Average	❑Average	❑Above Average
Emotional Expression	❑Below Average	❑Average	❑Above Average

For each type of development that you rated as *Below Average*, describe your current *Specific* areas of concern.

Medical History

Physician Name: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ **By Whom:** _____ **Phone:** _____

Results: _____

Immunizations Check the immunizations for the following diseases:

❑ Chicken Pox ❑Diphtheria ❑ German Measles ❑Measles ❑Mumps
❑Polio ❑ Small Pox ❑Tetanus

Drug Allergies: *

List any major illness and/or operations

Has the child had any medical hospitalizations in the last three years ❑ No ❑ Yes, if yes, complete below:

Hospital	City	Date	Reason

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):

List any *past* physical concerns:

Has the child ever had head trauma that resulted in loss of consciousness and/or required medical treatment? ❑ No ❑ Yes

What medications is client now taking? *List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.*

Prescription/Over the Counter Medication: ❑No ❑ Yes	**Out of Medication:** ❑ No ❑ Yes
Current Medication: ___________________ **Total Daily Dosage:** ____________ **Reason:** _____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ___________________ **Total Daily Dosage:** ____________ **Reason:** _____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: ___________________ **Total Daily Dosage:** ____________ **Reason:** _____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ___________________ **Total Daily Dosage:** ____________ **Reason:** _____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown
Current Medication: ___________________ **Total Daily Dosage:** ____________ **Reason:** _____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown	**Current Medication:** ___________________ **Total Daily Dosage:** ____________ **Reason:** _____________________ **Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

Does the client/family think medications help the client get better? ❑ N/A ❑ No ❑ Yes ❑ Unknown

Does your child use caffeine? ❑ No ❑ Yes from (coffee, tea, soda)____________________ Daily Use_____________
Does your child use tobacco? ❑ No ❑ Yes from (cigarettes, snuff, snus) __________________ Daily Use_____________

On the average, how many hours of sleep does your child receive nightly? _______________

After going to bed, how long does it take your child to fall asleep? _______________

If falling asleep is a problem, how long has it been a problem? _______________

Does your child regularly awaken in the night? ❑ No ❑Yes

Does your child regularly have bad dreams or nightmares? ❑ No ❑Yes

Does your child experience bad dreams and is unable to awaken during them? ❑ No ❑Yes

Describe your child's appetite? ❑ Poor Appetite ❑Average Appetite ❑Large Appetite
Has the child's weight changed in the last year? ❑ No ❑Yes If yes, by how much? ___________ **❑ weight gain ❑ loss**

Has client had any of the following symptoms in the past 60 days? ***Please check*.**

❑ Bedwetting	❑Coughing	❑Lightheadedness	❑Sleep Problems
❑ Blood in Stool	❑Diarrhea	❑Memory Problems	❑Seizures
❑ Breathing Difficulty	❑Dizziness	❑Muscle Weakness	❑Tingling in Arms/Leg
❑ Confusion	❑Falling	❑Nervousness	❑Tremors
❑Consciousness Loss	❑Gait Unsteadiness	❑Panic Attacks	❑ Vision Changes
❑Constipation	❑Hearing Loss	❑Pulse Irregularity	❑ Vomiting

❑ Other: ____

Has the client <u>or any relatives (related by blood)</u> had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother, sister, aunt/uncle, cousin, children, etc.) in the comment section.

	Client			Family History	
Problem	**Now**	**Past**	**Never**		**Relationship to the Client**
AIDS					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					

If the client has had any of the above , please write the problem, what treatment was received, and when

Problem & Treatment received:	**When**
Problem & Treatment received:	**When**

Educational History			
School: _____ **Highest Academic Year completed:**_____		**Highest Vocational Year Completed: (if applicable)**_____	
Type of school placement: ❑ Regular	❑ Special Education	❑Home-Schooled	❑Unknown
Type of Special Education Placement:	❑ None ❑Learning Disability ❑Other: _____	❑Cognitive Disability ❑Multiple Disabilities	❑Emotional Disability
Does your child experience any of the following problems (check all that apply)**:** ❑ Poor Attendance	❑Poor Grades	❑Suspension/Expulsion	
Has your child ever been retained in a grade? ❑ No ❑ Yes **If yes, which grade(s):** _____			
Has your child passed the school's proficiency tests? ❑Yes ❑No		❑ Does not apply	
Does your child have special communication needs? ❑ TTD Device ❑Interpreter Services			

Legal History and Children Services Involvement	
Legal Guardian(s)/Custodians	**Phones**
Current Legal Status ❑None ❑On Probation ❑Detention ❑On Parole ❑Awaiting Charges ❑Other _____	
Convictions	
Incarcerations	
Probation/Parole Officer (if applicable):	**Phone:**
Juvenile Court Involvement (for Child Abuse, Neglect or Dependency) **Current** ❑No ❑Yes **Past** ❑No ❑Yes	
Family Court Ordered into Counseling ❑No ❑Yes	
Juvenile Court Case worker (if applicable):	**Phone:**
Civil Court Proceedings:	
Domestic Relations Court Involvement (i.e. Custody, Protective Services, Restraining Order):	
Child Support Enforcement Orders:	
Children's Protective Services Involvement with Family: ❑No ❑Yes	
Name of GAL/CASA assigned to family (if applicable):	**Phone:**
Name of Children Services Caseworker assigned to the family (if applicable):	**Phone:**

_____ **Print Name** (Person completing questionnaire):	_____ **Signature:**	_____ **Date:**
Staff only _____ **Reviewer Name/Degree** (if applicable)	_____ **Signature:**	_____ **Date:**

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or to give a less than 24-hour notice on cancellations will result in a $35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this. * Note to Parents – if you are financially responsible (the signer on this form) for your child, it is your responsibility to make sure you know when your child's appointments are, and it is your responsibility to pay this fee if the appointment is missed. Continued non-compliance in keeping your appointments can result in dismissal from the practice.**

I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY OR HAD ACCESS TO IT ON THE WEBSITE. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

_____

Responsible Party/Legal Custodian Signature Date

_____

Witness Date

PRIME BEHAVIORAL HEALTH, LLC
CONSENT FOR TREATMENT AND INFORMATION SHEET

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-60 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As being the responsible party for a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself (and your child) – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you and your child.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owe Prime Behavioral Health.

We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself, your child, or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND CONSENT FOR TREATMENT.

_____ _____ _____
Responsible Party Signature **Printed Name of Client** **Date**

IF CLIENT IS A MINOR, PERSON SIGNING THIS FORM ATTESTS TO HAVING LEGAL CUSTODY AND CONSENTS TO FEES AND TREATMENT BY THIS SIGNATURE.

_____ _____
Parent Signature **Date** **Revised 10/15**

Prime Behavioral Health

647 Hill Rd. N Ste. B **711 N. Columbus St., Ste., 100**
Pickerington, OH 43147 **Lancaster, OH 43130**

COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = $120 *per hour (Minimum = $480)*
- Fees for court related activities requested less than two weeks in advance = $240 *per hour (Minimum - $960)*

Cancellation Policy

- If request for court related activities is cancelled 2 weeks prior to scheduled appearance the client will be entitled to a full refund minus an time the counselor used for preparation.
- If request for court related activities is cancelled 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

_____

Signature of Responsible Party/Legal Guardian Date

_____

Client name

Your signature states that you are aware of this policy. Please sign even if you feel that this will not apply to your situation.

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FEE SCHEDULE
All Counselors

Initial Session	**$160**
Office Visit ~60 Min	**$150**
Office Visit ~45 Min	**$120**
Office Visit ~30 Min	**$ 80**
Family Counseling ~45 Min	**$130**

I have read and understand the Financial Policy and office procedures at Prime Behavioral Health, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.carebyprime.com .

_____
Client Name (please print)

* *

If the client is a minor, the Guardian must sign below:

_____
Responsible Party/Legal Guardian Name (please print)

_____ _____
Responsible Party/Legal Guardian Signature **Date**

_____ _____
Witness **Date**

Revised 10/15

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Receipt of Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that on _____ I received the Notice of Privacy Practices of Prime Behavioral Health, LLC, or was notified of its availability on the website during my initial call, which sets forth the ways in which my personal health information may be used or disclosed by Prime Behavioral Health, LLC, and outlines my rights with respect to such information.

Please list anyone to whom we may speak or leave a message in regard to appointments or payments/billing along with their relationship to the client:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

Would you like for us to leave information regarding scheduling and appointments on your voicemail?

_____ YES _____ NO

Signature _____

Date _____

January 2016

APPOINTMENT REMINDERS THROUGH EMAIL

We can send you an appointment reminder by email as opposed to a phone call. The appointment reminder will include ONLY THE DATE AND TIME OF YOUR APPOINTMENT AND YOUR SERVICE PROVIDER NAME. We will not encrypt the messages. Health care information sent by regular email could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm that you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Do you agree to receive your appointment reminders via email?

_____ YES _____NO (check here if you prefer phone calls for reminders)

(If yes, please provide your email address. Also, if yes, please inform us of any changes or updates to your email address as they occur.)

_____

Email address (if not already provided)

I have read and understand the risks involved with accepting my appointment reminders via email.

_____ _____

SIGNATURE DATE

_____

CLIENT PRINTED NAME