BEHAVIORAL PEDIATRIC AND FAMILY THERAPY PROGRAM

Account # ______________________

Patient Last Name First MI Birthdate Gender

Street Address/Apt # City State Zip Best Contact Phone

Only a patient or his/her legal guardian can be the responsible party unless someone else gives their written consent

RESPONSIBLE PARTY'S NAME____
Last Name First MI

Birthdate ________________________ SSN ________________________

Address ________________________ City __________ State ______ Zip ______

E-Mail Address ________________________ Employer Name ________________________

Cellular Phone ______________ Work Phone ______________ Home Phone ______________

SPOUSE or
OTHER PARENT ____Birthdate ______________

Address ________________________ City __________ State ______ Zip ______

Employer ________________________ Cellular Phone ______________ Work Phone ______________

OTHER ____ Birthdate ______________
(partner, noncustodial parent, step-parent, or foster parent, etc.)

Address ______________ City __________ State ______ Zip ______ Home Phone ______

Employer ________________________ Cellular Phone ______________ Work Phone ______________

Emergency Contact other than parent or spouse
Name ________________________ Relationship ______________ Phone ______________

PRIMARY INSURANCE COMPANY
Insurance Company ________________________
Name of Policy Holder ________________________
Member ID Number ________________________
Group Number (if any) ________________________

SECONDARY INSURANCE COMPANY
Insurance Company ________________________
Name of Policy Holder ________________________
Member ID Number ________________________
Group Number (if any) ________________________

LIST ALL SIBLINGS OR CHILDREN OF PATIENT STARTING WITH FIRST BORN

NAME	BIRTHDATE	SEX	DIAGNOSIS (FOR OFFICE USE ONLY)

I hereby authorize Behavioral Pediatric and Family Therapy Program to release any information acquired in the course of treatment to my insurance carrier. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments directly to the psychologist/therapist. Pursuant to any applicable provider relations' agreement, I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature ____ Date ______________

Behavioral Pediatric & Family Therapy Program
Office Policy

The information in this packet is provided to assure that you have a full understanding of our office policies. Please read this carefully, ask any questions you may have, and sign where indicated. The following signatures must be secured before you can be treated in our clinic.

Financial Agreements and Authorizations for Treatment

I authorize treatment for the named person and agree to pay all fees for such treatment. I agree to pay for members of my family and for myself at the time of service unless other credit arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date.

Your signature below indicates you have received and read the information included on the following pages regarding the Behavioral Pediatric and Family Therapy Program office policies, informed consent and confidentiality statement and agree to abide by the stated terms during our professional relationship. Please read and review the following pages and keep them for your reference. Thank you for your attention to these matters.

_____________________________ _____________________________ ____________

(Patient Name) (Signature of Parent or Guardian) (Date)

Confirmation Telephone Calls

It is our practice to remind you of an upcoming scheduled appointment. Please respond to the following questions related to these automated contacts:

Please choose **ONE**: ❑ Call ❑ Text ❑ E-Mail ❑ No reminder

(Note: If no option is selected, a reminder will be made via automated telephone call)

Telephone number for reminder calls ____

Telephone number for reminder text messages ______________________________________

E-Mail address for reminder e-mails ____

Communication with Physician

In order to provide the highest level of care, we request permission to release relevant aspects of the patient's case to the primary care physician and/or medication prescriber. Please complete the following and checkmark the appropriate choice. If you have any questions, please discuss them with your physician or therapist.

____

(Patient's Primary Care Physician Name)

❑ Yes, you may release relevant aspects of the patient's case to the physician named above.
(PLEASE COMPLETE RELEASE OF INFORMATION FORM)

❑ No, I do not want the patient's case released to the physician, pediatrician, or medication prescriber.

Behavioral Pediatric & Family Therapy Program

Client Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

______________________________	____________________________________	_____________________
Patient Name	Signature of Patient or Legal Guardian	Date

Behavioral Pediatric & Family Therapy Program
Office Policies and Informed Consent

The information in this document is provided to assure that you have a full understanding of our office policies. Please read carefully, initial each section, and sign the bottom of page 3.

_____ Fees

If you have eligible health insurance, we will submit the following charges to your insurance company: Fee for the initial diagnostic session is **$345.00**. Fee for each subsequent therapy session is **$280.00**. An additional **$30.00** fee may be added to sessions that meet national current procedural terminology criterion for complex sessions. Fee for school meetings and observation is **$280.00**. Fees for testing and evaluation are **$275.00** for the first hour and **$220.00** for each subsequent hour. Testing time may include direct patient contact plus administrative time (e.g., scoring, interpretation, report writing, etc.). Provider-directed telephone calls regarding patients are typically included as a part of the fees for therapy or assessment with your providers, unless other arrangements are made with the provider.

If, for any reason, your provider is required to speak with attorneys or appear in court, reimbursement is expected from the party responsible for the provider's participation. Your insurance carrier will not pay for these charges. The rate is $**275.00** per hour for review of records, preparing letters/reports, and phone calls. The rate is **$440.00** per hour for a deposition or court testimony, including travel time. If you have any questions about fees for your sessions, please discuss these with your provider.

_____ Additional Paperwork

It is your responsibility to notify our office as soon as possible of any changes in insurance, address, or telephone numbers. You will be expected to complete updated paperwork when there has been a break in services for six months or longer.

_____ Payment Policy

Our policy requires payment in full at the time services are rendered unless other arrangements have been made in advance. If you have arranged a payment plan with our billing office, we ask that your balance not exceed **$280.00**. If this should occur, you will be asked to pay your balance in full, or at least a large percentage, before any additional appointments are scheduled. Unpaid balances of 90 days or longer may be assessed a re-billing charge of 1% per month until the balance is paid. If no payment is received within a reasonable period of time, we reserve the right to begin collection procedures.

Please note, the individual who initiates therapy is responsible for payment and will receive billing notices from our office. Nebraska law indicates that the custodial parent has ultimate financial responsibility for payment regardless of the divorce decree. This individual, not our office, is responsible for settling any financial obligations with the noncustodial parent.

_____ Insurance

Pursuant to any applicable provider relations agreement, your insurance is a contract between you and your insurance company. Your account with this office is your responsibility. Insurance cannot be filed without the signature of the responsible party on our initial paperwork. Please contact your health insurance carrier if you have questions regarding your insurance coverage. Payment of account balances will be requested at the time of check in.

_____ Cancellations / Missed Appointments

We understand that, at times, it may be necessary to cancel an appointment. To help us schedule our time most efficiently, we ask that any changes or cancellations be made at least 24 hours in advance. If cancellations are not made at least 24 hours in advance, or if an appointment is missed without a call, **you may be subject to a $30.00 fee.** This fee is your responsibility and is not covered by your insurance policy. If a pattern of missed appointments with late or no notice develops, further sessions with your provider may be declined and referral to a different group recommended.

______ Evaluations / Home Visits / School Meetings and Observations

Fees for psychological and neuropsychological testing and school evaluations will vary and may not be covered by your insurance policy. If you do not fully understand what fees will be incurred, please discuss this issue with your psychologist. Fees for home visits, school meetings, and observations are determined by the amount of time spent in the home or school, as well as distance traveled. Payment of these fees is your responsibility if these services are not covered by your insurance company.

______ Child Psychotherapy with Separated / Divorced Parents

Unless a parent/legal guardian has sole legal/medical custody (our office requires a copy of the custody agreement), both parents/legal guardians must consent to treatment in order for your child to be seen in our clinic. Psychotherapy for children when parents are separated or divorced can present unique circumstances. Psychotherapy is most successful when parents are involved in the therapy process. The best outcomes occur when the provider has a working relationship with both parents built upon collaboration and a desire to promote your child's best interest. The provider will work with each parent to achieve successful co-parenting, as this is one of the best predictors of children's adjustment and psychological health when parents are separated or divorced. It is not a provider's role to provide custody evaluations or opinions about parental fitness. Your provider will discourage the release of your child's mental health records to your attorneys. Please inform your attorneys not to subponena your child's provider or child's mental health records. Any requests for release of information to either parents or a third party must be signed by both parents. If there is a court-appointed evaluator, your provider will provide the evaluator with general information about your child, but will not include opinions about custody or parental fitness.

______ Minors and Parents

Patients under 19 years of age who are not emancipated should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, your provider will provide only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Before giving parents any information, your provider will discuss the matter with the child and do his/her best to handle any objections he/she may have. Any other communication will require the child's authorization, unless your provider feels the child is in danger or is a danger to someone else, in which case, your provider will notify the parents of their concerns.

______ Records

Our office is required to maintain records for seven (7) years following the discontinuation of services, or for seven (7) years past the age of majority (19 years) in Nebraska.

______ Confidentiality

In general, the confidentiality of all communications between a patient and provider is protected by law, and your provider can only release information about our work to others with your written permission. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent your provider from providing information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings where your emotional condition is an important element, a judge may require your provider to testify if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which your provider is legally required to take action to protect others from harm, even though revealing some information about a patient's treatment. For example, if your provider believes that a child, an elderly person, or a person with a disability is being abused, he/she may be required to file a report with the appropriate state agency. If your provider believes that a patient is threatening serious bodily harm to another, he/she may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, your provider may be required to seek hospitalization for the patient, notify police, or to contact family members or others who can help provide protection. These situations rarely occur. However, if such a situation develops, your provider will make every effort to fully discuss it with you before taking action.

You should be aware that, pursuant to HIPAA, your provider keeps Protected Health Information about you/your child as part of their professional records. It includes information about you/your child's reasons for seeking therapy, a description of the ways in which you/your child's problem impacts on your life, diagnosis, treatment goals, progress toward these goals, medical and social history, treatment history, past treatment records (if applicable), professional consultations, billing records and any reports or requests that have been sent to anyone, including reports to your insurance carrier.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your record be amended; requesting restriction on what information from your Clinical Records is disclosed to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policy and procedures. The Office is also required by HIPAA to inform you if we become aware of or suspect a breach of your Protected Health Information.

Your provider may occasionally find it helpful to consult about a case with other professionals. In these consultations, he/she will make every effort to avoid revealing the identity of the patient. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your provider will not tell you about these consultations unless he/she feels it is important to your work together. Providers for the Behavioral Pediatric and Family Therapy Program are independent providers and share no joint liability.

_____ Risk Assessment

You should be aware that your contract with your insurance company requires that we provide it with information relevant to the services that we provide to your child and/or you. We are required to provide a clinical diagnosis. Sometimes, we are required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that we can provide requested information to your insurance carrier.

_____ Communication via Text Message

You should be aware that text messages are not HIPAA-compliant; therefore, your provider will not respond to a text message sent to his/her cellular telephone.

While this written summary of policies and exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns with your provider. The laws governing these issues are quite complex and your provider is not an attorney. While he/she may be happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your provider will provide you with relevant portions of summaries of the applicable state laws governing these issues.

By signing below, you indicate that you have read, understand, and agree to comply with the policies described above. You are also consenting to treatment and acknowledge that you have received consent (either verbally or in writing) from the noncustodial parent/legal guardian.

____

Patient Name

____ ______________________________

Signature Date

Behavioral Pediatric & Family Therapy Program
Child Family Inventory

PATIENT INFORMATION

Patient Name: ____ Nickname: _______________________

Age: ____________ Birth date: _________________________________ Gender: ______________________

Address: ____ Phone: _______________________

Parent / Legal Guardian Name: ____ Age: ________

Relationship to Patient (check one):

___Biological ___Adoptive ___Foster ___Step Married: __________ Divorced: __________
Date Date

Parent / Legal Guardian Name: ____ Age: ________

Relationship to Patient (circle one):

___Biological ___Adoptive ___Foster ___Step Married: __________ Divorced: __________
Date Date

Name of Other Member(s) of the Household:	Age	Gender	Relationship
____	________	________	________________
____	________	________	________________
____	________	________	________________
____	________	________	________________

Who Referred You? _______________________________ Patient's Physician: ____________________________

Reason for Referral? ____

____

PATIENT ASSESSMENT

Complications with fertility, pregnancy, labor/delivery: ____

____

Growth and Development:

General impression of infant development: (circle one) ____Poor ____Fair ____Good

Note the month patient achieved the following activities:

Sat Alone _________ Crawled _________ Walked _________ Feed Self _________ Spoke Words _________
(Typical: Sit, 6-8 mo.; Crawl, 9 mo.; Walk, 12-18 mo.; Feed, 10-12 mo.; Speak, 10 mo.)

General Appearance: ____

Weight: _______________ Height: _______________

Physical Assessment of Vision, Hearing, and Speech:

Vision: ____Normal ____Abnormal ____Corrected

Hearing: ____Normal ____Abnormal ____Corrected

Speech: ____Normal ____Abnormal ____Corrected

Does patient have a physical health problem which interferes with normal functioning? ____Yes ____No

If yes, describe: ____

____

Has patient had any genetic or medical testing done in the past? ____Yes ____No

If yes, what type of testing and by whom? ____

____

Is patient on any medications at the present time? ____Yes ____No

Name of medications (prescribed and over-the-counter): ____

____

Do any of the medications affect patient's behavior? ____Yes ____No

How? ____

Emotional Status:

Does patient have a behavioral or emotional problem that concerns you? ____Yes ____No

If yes, describe: ____

____

Has patient ever received counseling or psychotherapy? ____Yes ____No

If yes, describe reasons for counseling / psychotherapy, therapist name(s), and date(s):

____

____

Is the relationship good between patient and parent(s) / guardian(s)? ____Yes ____No

If no, elaborate: ____

Is the relationship good between patient and other household members? ____Yes ____No

If no, elaborate: ____

Which of the following have been or are now problems with patient?

	Yes	No	Sometimes		Yes	No	Sometimes
Won't Mind	______	______	______	Soiling	______	______	______
Too Active	______	______	______	Bedwetting	______	______	______
Bad Temper	______	______	______	Cries Too Much	______	______	______
High Strung or Nervous	______	______	______	Clings to Parents	______	______	______
Breath holding	______	______	______	Toilet Training	______	______	______
Easily Upset	______	______	______	Lying	______	______	______
Clumsy	______	______	______	Too Shy	______	______	______
Night Terror	______	______	______	Siblings	______	______	______
Destructive	______	______	______	Hyperactive	______	______	______
Head banging	______	______	______	Other	______	______	______

When did you first notice concerns? ____

SCHOOL ASSESSMENT

Patient school: _________________________ City/State: ____________________ Grade: ________

Teacher Name: ____________________________ Principal Name: ____________________________

Hours in attendance: ____

Is patient home-schooled? ____Yes ____No

Hours in attendance: ____

Describe school progress (circle one) ____Poor ____Fair ____Good ____Very Good

According to the teacher, patient:	Yes	No	Sometimes	Date of Onset
Has difficulty following instructions	______	______	______	________________
Speech / Language concerns	______	______	______	________________
Completing assignments	______	______	______	________________
Talks out of turn	______	______	______	________________
Learning difficulties	______	______	______	________________
Has a short attention span	______	______	______	________________
Has trouble finishing work	______	______	______	________________
Does not get along with other children	______	______	______	________________
Has poor school attendance	______	______	______	________________

Have you had special or extra conferences with teacher or school authorities for behavior or learning problems?
____Yes ____No

Does patient receive any Special Education Services? ____Yes ____No

Has patient ever been tested for learning, behavior, or speech problems? ____Yes ____No

Does patient have an IEP / 504 Plan? ____Yes ____No

What do they suggest is needed to help patient? ____

____

Do you agree with teacher, or what are your ideas about what is needed? _____________________________

____

Is patient involved in extracurricular activities? ____Yes ____No

If yes, describe: ____

FAMILY ASSESSMENT

Parent / Guardian Name: ______________________________________ Education: _________________________

Employer / Job Position: _______________________________________ Work hours: ________________

Describe overtime work or second job: ____

Home schedule: ____

____

Parent / Guardian Name: ______________________________________ Education: _________________________

Employer / Job Position: _______________________________________ Work hours: ________________

Describe overtime work or second job: ____

Home schedule: ____

____

Do you think the family is under financial strain? ____Yes ____No

Are you receiving any type of financial assistance? ____Yes ____No

Describe past or recent stressors: ____

Describe past or recent legal issues: ____

Describe any neglect / trauma history: ____

Describe a typical day experienced by your family: ____

____

____

Has either parent / guardian received medication, counseling, or psychotherapy? ____Yes ____No

If yes, describe the issues and diagnoses: ____

____

Therapist name(s) and date(s): ____

____

How would you describe your marriage / relationship during the past six months? (circle one)

____Very Good ____Good ____Fair ____Bad ____Very Bad ____N/A

How would you describe your marriage / relationship during the last month? (circle one)

____Very Good ____Good ____Fair ____Bad ____Very Bad ____N/A

Does either parent / guardian have a physical health problem that interferes with normal functioning?

____Yes ____No If yes, please describe: ____

____

CHILD MANAGEMENT

Who ordinarily disciplines patient? ____

How is patient disciplined? ____Timeout ____Spank ____Yell ____Take Privileges

____Send to Room ____Reasoning

Other (describe): ____

How often do you need to use discipline? ____

Have your methods of discipline been effective? ____Yes ____No

Do you and patient's other parent / guardian agree on discipline? ____Yes ____No

What does patient like to do with you?

Parent / Guardian Name: ____

Preferred activities: ____

Parent / Guardian Name: ____

Preferred activities: ____

SIBLING ASSESSMENT

Emotional status:

Has any sibling received counseling or psychotherapy? ____Yes ____No

If yes, describe the issues and diagnoses: ____

____

Therapist name(s) and date(s): ____

____

Does any sibling have an emotional or behavioral problem that concerns you? ____Yes ____No

If yes, describe: ____

____

ADOLESCENT ASSESSMENT

(If applicable, please complete the following)

To your knowledge, has your adolescent:

Used alcohol or drugs ____Yes ____No

If yes, explain: ____

____

Had a positive drug screen ____Yes ____No

Had a SCIP evaluation ____Yes ____No

Used tobacco ____Yes ____No

Been sexually active ____Yes ____No

Run away from home ____Yes ____No

Had legal difficulties ____Yes ____No

If yes, please explain (probation officer, court date, etc.): ___________________________________

____

Other concerns not mentioned: ____

Does your adolescent have difficulties with any of the following:

	Often	Occasionally	Seldom	Never
Curfews	_________	_________	_________	_________
Skipping school	_________	_________	_________	_________
Failing grades	_________	_________	_________	_________
Peers	_________	_________	_________	_________
Suicide threats or attempts	_________	_________	_________	_________
Destruction of property	_________	_________	_________	_________
Aggression	_________	_________	_________	_________