CHILD/ADOLESCENT INTAKE (18 years & younger)

Child's Name:______________________MI__________ Last______________________________

Date of Birth____________________ □ Male □ Female

Child's Primary Care Physician______________________________Phone:____________________
Fax:

The client (child) resides with: ____

The legal guardian (s) of the client (child) is: ____________________________________

*Mother's Name*____ □ Biological
□ Step-mother
Address: ____ □ Adopted

Phone/Home______________________Work_______________Cell ____________________

Father's Name ____ □ Biological
□ Step-mother
Address: ____ □ Adopted

Phone/Home ______________________ Work_________________ Cell __________________

*Other Parent/Guardian*___________________________________ □ Step Parent
□ Guardian
Address:____

Phone/Home ______________ Work___________ Cell______________________________

*Other Parent/Guardian*___________________________________ □ Step Parent
□ Guardian
Address:____

Phone/Home ___________________Work___________________ Cell___________________

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: ______________________________ Phone_____________________________

Relationship to Client: ____________________ Work ______________________________

INSURANCE COMPANY INFORMATION

Please submit your insurance card at your first appointment so that we may make a copy of it.

Policy Holder Name:_________________________________ DOB:______________________

Address (if different from above):____

Member ID # __________________________ Group ID#_____________________________

City:__________________________State:________Zip:___________________________

Phone (h)________________________(w)__________________________(c)______________

Employer of Policy Holder:____

Primary Insurance Company Name:____

Secondary Insurance Company Name:____

CHILD & ADOLESCENT SURVEY

DATE ____________________

Name ______________________________ DOB: ______________________________

Nickname (name child responds to) ______________________________

Sex ____________ Person Completing Form ______________________________

PRESENT PROBLEM

Describe the problem that brings you here ______________________________

In what settings does the problem occur? (Circle all that apply)

Home Daycare School Sports/Clubs

Who is most bothered by the problem/behavior? ______________________________

Who is least bothered by the problem/behavior? ______________________________

What strategies have been implemented to address these problems?

Verbal reprimands time out removal of privileges rewards

Physical punishment acquiescence to child avoidance of child

On the average, what percentage of the time does your child comply with initial commands? (circle one)
0-20% 20-40% 40-60% 60-80% 80-100%

On the average, what percentage of the time does your child eventually comply with commands?
0-20% 20-40% 40-60% 60-80% 80-100%

To what extent are you and your spouse consistent with respect to disciplinary strategies?

_____ Some of the time _____ Most of the time _____ None of the time

SOCIAL HISTORY

Who lives in the home (include pets) ______________________________

Location and relationship of extended family ______________________________

How does your child get along with his/her brothers/sisters?

How easily does your child make friends? ______________________________

On the average, how long does your child keep friendships? ______________________________

____

Does your child get into fights? Yes No

____

FAMILY HISTORY

Family history of emotional problems (mental illness or childhood behavior problems, suicide…etc.)

____

____

____

As a child, did anyone in the family have problems with….

…attention span, activity, or impulse control? YES NO
…problems with aggressiveness or defiant behavior? YES NO
…learning disabilities? YES NO

Were there any suicide attempts, suicides, or homicides in the family? YES NO

Who? What Relationship? ______________________________

Are there any members of the family with drug or alcohol abuse history? YES NO
If yes, what is the nature and duration of the problem?

____

____

Has anyone in the family been physically or sexually abused? YES NO

____

____

DEVELOPMENTAL HISTORY

Was the child the result of a planned pregnancy? YES NO

How did you and your spouse feel about the pregnancy? ______________________________

Was prenatal care received? YES NO Started ________ Month

Did mother have: anemia, toxemia, high/low blood pressure, kidney or heart problems, bleeding, measles, other illnesses, or injury? (circle all that apply)

Did mother use: alcohol, other drugs, caffeine or cigarettes (circle all that apply)

Type of delivery: vaginal, cesarean. Were forceps used? YES NO

Birth weight____________ Problems at birth? Required oxygen, cord around neck, breech birth, other…______________________________

Was baby: premature, at term, post term? ______________________________

Was your child early, late, on schedule with developmental milestones?

At what age did child: sit up________________ stand alone________________ walk alone________________

use words ________________________ use sentenances ________________________

At what age was your child toilet trained (bladder control)?

under 1 yr _____ 1-2 yrs _____ 2-3 yrs _____ 3-4 yrs _____

At what age was your child toilet trained (bowel control)?

under 1 yr _____ 1-2 yrs _____ 2-3 yrs _____ 3-4 yrs _____

How would you rate your child on the following:

	Very Easy	Easy	Average	Difficult	Very Difficult
Eating					
Sleeping					
Cuddling					
Response to Affection					

Other comments: ______________________________

MEDICAL HISTORY

1. Who is your child's physician? ______________________________

Date of last exam ____________________ Medications ____________________

____

2. How would you describe your child's health?

____

____

3. Does your child have any physical illnesses presently? YES NO

____

____

4. Has your child ever been hospitalized? YES When? What problem? How long?

____

____

5. Has your child ever been unconscious or had a head injury? YES NO

____

6. Does your child have any allergies? YES NO
   If yes, to what? ______________________________
   Does your child require an Epipen? YES NO

7. Is there any suspicion of alcohol or drug use? YES NO

____

8. Is there any history of physical/sexual abuse? YES NO

____

9. Does your child have any problems sleeping? YES NO

____

10. Does your child have bladder or bowel control problems? YES NO

____

11. Does your child have any appetite control problems? (overeats, average, under-eats) YES NO

____

12. Has your child ever had suicidal thoughts; made a suicide attempt or engaged in self harm? YES NO

____

Any other medical problems, serious illness, injury or hospitalization? ____________________

____

____

____

EDUCATIONAL HISTORY

Current School ______________________ Current Grade ____________________

Teacher ______________________ Repeated Grade ____________________

What grades does your child receive? ____________________________________

Has your child received suspension or expulsions? YES NO

How does your child get along with:

Teachers:

____

Classmates: ____

Has your child ever been referred to IEP or 504 Committee or had any special testing in school? YES NO

____

Has your child had academic accommodations such as a behavioral modification program or a daily/weekly report?
YES NO

____

____

____

____

____

____

HISTORY OF LOSSES AND STRESSORS (Check all that apply)

_____ Moved to a new place
_____ Changed School
_____ Serious illness or injury in family
_____ Death in family
_____ Change in financial status
_____ Promotion
_____ Demotion
_____ Loss of job
_____ Change in job
_____ Mom starting work outside the home
_____ Change in childcare
_____ Change in school
_____ Bullied
_____ Divorce or separation
_____ Sibling leaving home
_____ Birth of new sibling
_____ Death of pet
_____ Serious accident or illness of a friend
_____ Change in child's friendships
_____ Change in child's attitude or personality
_____ Child abuse or neglect

Additional Comments or questions:

____

____

____

____

____

Chester River Behavioral Health, LLC
FEE AGREEMENT & INSURANCE AUTHORIZATION

Fees for Services

Initial Evaluation	Individual	$200.00/hr.
	Couples/Families	$225.00/hr.
Individual Psychotherapy (30 min.)		$100.00
Individual Psychotherapy (45 min.)		$125.00
Individual Psychotherapy (60 min.)		$185.00
Couples/Families (45 min.)		$150.00
Group Psychotherapy		$ 50.00
Psychological Testing/Evaluation		$125.00/hr.
Phone Conversation > (5 min.)		$185.00hr.
School Conferences or Meetings (mtg/travel time+mileage @..585 per mi.)		$185.00/hr.
Court Testimony or Depositions (mtg/travel time+mileage @.585 per mi., retainer required)		$200.00/hr.
Emergency/Crisis Evaluation (individual)		$275.00/hr.
Letter Writing		$185.00 per hr.
Records Fees		$ .85 per page
Preparation Fee		$ 22.88 + postage
Fail to Keep Appointment		$125.00
Failure to Provide 24 Hour Notice		$ 60.00
Return Check Fee		$ 35.00
Record Review		$ 60.00 per hr.
Urinalysis		$ 30.00

I am aware that if I am utilizing my health insurance to pay for any of the above services. I am responsible for any deductible and/or co-payment as outlined in my current policy. I agree to make the required payment at the time of service. I also agree I will pay in full all balances owed to Chester River Behavioral Health & Wellness, LLC should my insurance company not make payment.

Payment for services for minors: the amount due for each session must be paid in full upon arrival. Chester River Behavioral Health & Wellness, LLC will not divide co-payments due to court orders, divorce decrees, or separation agreements. Whoever brings the minor to the appointment is expected to make the payment, or, if minor comes alone, or arrangement for payment must be made in advance.

I am aware that cancellations of appointments (except for situations which would be considered emergencies) must be made with 24 hours advance notice. If I am unable to cancel with adequate notice, I agreed to pay a $60 fee for that session. If I fail to keep my appointment without any notice, I will be charged $125 (see 45 min. appointment above). I am aware that my insurance does not cover missed appointments.

I am aware that I may terminate my treatment at any time without consequence and that I will be responsible for payment for the services I have received.

I am aware that failure to meet my financial obligation may result in referral to a collection agency. The patient, and/or guarantor, shall be responsible for and agree to pay all reasonable costs of collection including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs. If any suit must be filed to collect the unpaid balance own accounts, patient, and/or guarantor, agrees that such suit may be brought in courts of Kent or Queen Anne's County, Maryland and waives any objection to jurisdiction or venue.

I am aware that my insurance provider or its agent may request and be provided with information about the type, cost, and date of any treatment I received from Chester River Behavioral Health and Wellness, LLC so that payment may be provided to the therapist. I agree that this information may be released.

I am aware that the development of treatment plans and reviews of progress may be requested by my insurance provider or his agent. I agree to this information being released if my insurance provider or its agent request for authorization of treatment sessions and/or forge payment.

I have been provided a copy, have read, am aware of and agree to the terms described in the Maryland Know This Form Re: be Health Insurance Privacy and Portability Act (HIPPA).

This agreement shall remain in effect for the length of time, I am in treatment or until all financial obligations are met, whichever is longer.

Signature of Client (Parent) ______________________ Date __________ Printed Name ______________________

____

Witness

Chester River Behavioral Health, LLC
952 Washington Avenue
Chestertown, MD 21620
(410)778-5550

Maryland Notice Form

This Notice is Required by a New Federal Law, the Health Insurance Portability and Accountability Act (HIPAA). This Notice Describes How Psychological and Medical Information about You May be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.

I. Uses and Disclosures for Treatment, Payment, and Health-Care Operations

We must have your written authorization to *use* or *disclose* your protected health information (PHI) for any reason (with some exceptions discussed in Section III) including for treatment, payment, and health-care operations purposes. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, payment, and health-care operations"*
  - -Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health-care provider such as your family physician or another therapist.
  - -Payment is when we obtain reimbursement for your health-care. For example, when we disclose your PHI to your health insurer to obtain reimbursement for your health-care or to determine eligibility or coverage.
  - -Health-Care Operations are activities that relate to the performance and operation of CRBH. Examples of health-care operations are quality assessments and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health-care operations when you give us permission by signing an authorization form.

You may revoke all authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have acted upon that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances.

- *Child Abuse* - If we have reason to believe that a child has been subjected to abuse or neglect we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* - We must disclose protected health information regarding certain handicapped adults who may be victims of abuse, neglect, or self neglect/exploitation.
- *Health Oversight Activities* - If we receive a subpoena from a licensing board because they are investigating our practice, we must disclose any PHI requested by the board.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* - If you communicate a specific threat of imminent harm against another individual or if we believe that there is a clear, imminent risk of physical or mental injury being inflicted against another individual, we must make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself we must make disclosures to protect you from harm.

IV. Patient's Rights and Therapist's Rights

Patient's Rights

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. On your request, we will send your bills to another address).
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties

- We are required by law to maintain the privacy of PHI and to provide you with the notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice.
- Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise any policies and procedures, we will provide you with a revised notice.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the office's Privacy Officer, Teresa Schaefer. She can be reached at 410-778-5550.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for the PHI that we maintain. If we make any such changes, we will provide you with a new Notice of Privacy Rights.

Print Name______________________________

Signature______________________________ Date____________________

Please sign and return

CHESTER RIVER BEHAVIORAL HEALTH, LLC
CLIENT RIGHTS AND RESPONSIBILITIES

Statement of Clients' Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Only in an emergency, or if required by law, can records be related without Client permission.
- Clients have the right to have an easy to understand explanation of their condition and treatment.
- Clients have the right to know about their treatment choices regardless of cost or insurance coverage.
- Clients have the right to information about providers' professional credentials.
- Clients have the right to know the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on Chester River Behavioral Health's policies and services.
- Clients have the right to know about the complaint grievance and appeal process.
- Clients have the right to know about State and Federal laws that relate to their rights and responsibilities in the treatment process.
- Clients have the right to share in the formation of their treatment plan.

Statement of Clients' Responsibilities

- Clients have the responsibility to give providers the information they need to deliver the best possible care.
- Clients have the responsibility to ask their provider questions about their care, to follow plans and instructions for their treatment, and to let their provider know when their treatment plan no longer works for them.
- Clients have the responsibility to inform their provider about medication and medication changes.
- Clients have the responsibility to keep their appointments. Clients should provide 24 hours notice for any appointment they need to reschedule or cancel.
- Clients should respect the confidentiality of other clients.
- Clients have the responsibility to pay co-payments at the time of service.
- Clients are responsible for the supervision of their children. Children, who are unable to sit quietly in the waiting area, may NOT be left unsupervised.

- I have read and received a copy of my rights and responsibilities.

Signature______________________________

Dates ________________________________

Chester River Behavioral Health, LLC

952 Washington Avenue • Chestertown, MD 21620

PH (410) 778-5550 • FAX (410) 778-0984

www.chesterriverbehavioral.com

Richard G. Wirtz, PsyD   Teresa M. I. Schaefer, PhD

and affiliates

Patricia Deitz, LCSW-C   Robert Denison, LCSW-C   Heather Satterfield, LCPC   Dee Hirsh, LCPC

E-mail Appointment Reminder Consent Form

As an added service to our clients, we can send an appointment reminder by e-mail. 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 e-mail 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 e-mail, please confirm that you accept responsibility for these risks, and will not hold CRBH or your service provider responsible for any event that occurs after the message has been sent.

Failure to receive or read the e-mail does not alter your responsibility to keep your scheduled appointment as outlined in the fee agreement.

____________________ Client Signature

__________ Date

____________________ Print Name

____________________ E-mail Address

CREDIT CARD AUTHORIZATION FORM

Because there are times that our clients may not pay at the time of sessions (e.g. telehealth, forgotten checkbooks, minors coming to therapy without parents, etc.) we ask that you provide us with a credit card number to keep on file, to which any unpaid balance may be charged at the time of service. If credit card information is not provided, then a deposit equivalent to the charge for a single session will be required prior to the first appointment.

I, ______________________________, authorize Chester River Behavioral Health LLC. to keep my signature on file and to charge my credit card as outlined above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

NAME OF CLIENT: ________________________________

NAME OF CARDHOLDER: ___________________________

RELATIONSHIP TO CLIENT: __________________________

CARDHOLDER ADDRESS: ____________________________

CARDHOLDER PHONE: ______________________________

_____**VISA** _____**MASTERCARD**

ID# _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration date: _ _/_ _

CV code:_ _ _

__ ONE TIME ONLY
__ UNTIL FURTHER NOTICE
__ OTHER:

Authorized by: ____________________**Date** ________
Witness: ____________________ **Date** ________

Informed Consent for Telemedicine Services

Telemedicine involves the use of video conferencing to enable your clinician to provide continued care when face to face contacts are not possible (e.g. illness, injury, childcare, or transportation issues). For the purposes of continued care with CRBH, telemedicine is limited to live two-way audio and/or video contact.

1) I understand that my health care provider wishes me to engage in a telemedicine consultation.
2) I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
3) I understand that my healthcare information may shared with other individuals for scheduling and billing purposes.
4) I have had the alternatives to a telemedicine consultation explained to me.
5) I understand that I or my insurance will be billed for the telemedicine services provided and that I am responsible for the cost of the services not reimbursed by my insurance provider.

By signing this form, I certify:

- That I have read or had this form read and/or explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

____________________________________ _______________

Patient/Parent/Guardian Signature Date

____________________________________ _______________

Witness Signature Date