Children's
HOSPITAL & MEDICAL CENTER

We know children.

Welcome to Children's Behavioral Health

Thank you for choosing Behavioral Health. We want you to feel comfortable here. Since many individuals are unaccustomed to a situation in which their feelings and "problems" are the focus of attention, communication may at times feel awkward. There is a difference between conversation and therapy. If at any time you have questions about the course of treatment, feel free to discuss them with your provider. Please ask questions until you feel you understand.

Privacy and Confidentiality

Attached is a document entitled "Joint Notice of Privacy Practices," which applies to all entities of Children's Healthcare Services. Please be aware that the psychological records of Behavioral Health are kept separate from the medical records of the hospital, and thus are afforded additional assurance of privacy and confidentiality.

All psychotherapy records, as well as discussions that occur during appointments, are confidential. Such information is released to outside sources only upon consent of a signed "Authorization to Release Health Information" form. You may revoke this permission in writing at any time.

Confidential information may be released without consent as required by law. For example, the law requires a provider to release information if the provider feels that a patient is in a dangerous or abusive situation or thinks a client might harm herself/himself or others. There may be other situations in which the law compels the release of information.

Appointments

Efforts will be made to make appointments at a time that is convenient to you. It is important that treatment continues on a regular basis. When cancellations occur, please attempt to reschedule the appointment at the time of the cancellation or as soon as possible. You may be charged for appointments that are cancelled less than 24 hours in advance. In order that we may serve others who desire treatment, repeatedly missing appointments without notification may require discontinuation of services.

Payment

It is our policy that the client pays wholly or in part for services rendered before leaving the office. Your provider must discuss any variation from this policy with the director. Checks should be made payable to Children's Hospital. Debit cards, MasterCard, Discover, American Express and VISA are also accepted.

Emergencies/Phone Calls

We encourage you to discuss any problems or concerns during your regular appointments. If you need to talk directly to your provider between appointments, please understand that we will return calls as our schedules permit. It is often helpful to relay messages through the office staff when possible.

Honesty and Integrity

Again, thank you for choosing Children's Behavioral Health. Our goal is to assist you in dealing effectively with problems you are having while respecting your dignity, privacy and confidentiality. We are embarking on a cooperative effort, which can succeed only if we are open and honest with each other. We hope you will be comfortable with us and benefit from the experience.

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PATIENT INFORMATION

Patient Name: (legal name) _____ DOB: ____/____/____
First Middle Last

Sex: ___M ___F Marital Status: _____ Age: _____ SS#: ___-___-_____

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

Home Phone: ___-___-_____ Work Phone ___-___-_____ Cell Phone ___-___-_____

Please list a phone number for courtesy appointment reminder calls: ___-___-_____ voice or text (please circle)

Race _____ Religious Preference _____ Language: _____

Interpreter Needed? Yes No (please circle) Email address_____

Adult patients only – Employed by: _____ Full or Part time (please circle)

Insurance:

Primary Insurance: Insurance name: _____ Employer name: _____

ID#: _____ Group Number: _____ Relationship to Patient: _____

Policy Holder's Name: _____ DOB: ____/____/____ SS#: ___-___-_____
First Middle Last

Secondary Insurance: Insurance name: _____ Employer name: _____

ID#: _____ Group Number: _____ Relationship to Patient: _____

Policy Holder's Name: _____ DOB: ____/____/____ SS#: ___-___-_____
First Middle Last

Medicaid Information (if applicable)*: Medicaid ID number: _____ State: _____
(*please note: Medicaid will not pay if primary insurance is not submitted for billing.)

To be completed if patient is 18 or under:

Father's name: _____ DOB: ____/____/____ SS#: ___-___-_____
First Middle Last

Marital Status: _____ Home Ph: ___-___-_____Work Ph: ___-___-_____ Cell Ph: ___-___-_____

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

Employed by: _____ Full or Part time (please circle)

Legal Guardian? Yes | No Notify on hospital admission? Yes | No

Mother's name: _____ DOB: ____/____/____ SS#: ___-___-_____
First Middle Last

Marital Status: _____ Home Ph: ___-___-_____Work Ph: ___-___-_____ Cell Ph: ___-___-_____

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

Employed by: _____ Full or Part time (please circle)

Legal Guardian? Yes | No Notify on hospital admission? Yes | No

Emergency Contact Name: _____ Relationship: _____ Phone: ___-___-_____
First Middle Initial Last

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Pretreatment Questionnaire-Child/Youth

Patient Name _____ **Birth date** _____ **Today's date** _____

Form Completed by _____ _____ Parent _____ Legal Guardian

Referred by _____

Primary concern(s) for which treatment is sought:

_____

_____

_____

_____

Parents are: _____ married _____ divorced _____ separated _____ other:_____

How well is your child doing in the following areas:

	Poor				Excellent	
Grades in school?	1	2	3	4	5	NA
Behaving in school?	1	2	3	4	5	NA
Behaving at home?	1	2	3	4	5	NA
Getting along with family?	1	2	3	4	5	NA
Getting along with peers?	1	2	3	4	5	NA
Overall level of Functioning	1	2	3	4	5	NA

Individuals living in your home: (*Including Adults)

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Name _____ Age_____ Relationship _____

Individuals living in your home part-time:

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Developmental history:

Complications at birth or in early childhood? __ yes __ no If yes, please explain:

_____

Approximate age walked _____ Approximate age talked _____

Any known developmental delays? _____

_____

Medical Issues:

Date of your child's last physical exam_____ Physician's Name: _____

At any time has your child had the following:

1.	Asthma	☐ Never	☐ Past	☐ Present
2.	Allergies	☐ Never	☐ Past	☐ Present
	Type of allergies:_____			
3.	Diabetes, arthritis, or other chronic illnesses	☐ Never	☐ Past	☐ Present
4.	Epilepsy or seizure disorder	☐ Never	☐ Past	☐ Present
5.	Surgery	☐ Never	☐ Past	☐ Present
6.	Lengthy hospitalization	☐ Never	☐ Past	☐ Present
7.	Speech/language problems	☐ Never	☐ Past	☐ Present
8.	Hearing difficulties	☐ Never	☐ Past	☐ Present
9.	Eye/vision problems	☐ Never	☐ Past	☐ Present
10.	Fine motor/handwriting problems	☐ Never	☐ Past	☐ Present
11.	Gross motor difficulties, clumsiness	☐ Never	☐ Past	☐ Present
12.	Appetite problems (overeating or under eating)	☐ Never	☐ Past	☐ Present
13.	Sleep problems (falling asleep, staying asleep)	☐ Never	☐ Past	☐ Present
14.	Soiling problems	☐ Never	☐ Past	☐ Present
15.	Wetting problems	☐ Never	☐ Past	☐ Present

16. Serious injuries:

_____

_____

17. Explain any hospitalizations or surgeries:

_____

_____

_____

Immunizations current: _____ yes _____ no If no, explain: _____

Medications (prescribed and over-the-counter):

Medication _____ Dosage _____ Prescribing physician _____

Medication _____ Dosage _____ Prescribing physician _____

Medication _____ Dosage _____ Prescribing physician _____

Previous mental health treatment:

Mo/Yr ____ Provider _____ Treatment _____ Outcome _____

Mo/Yr ___ Provider _____ Treatment _____ Outcome _____

Family History:

Please indicate whether any of your child's blood relatives have experienced any of the following:

Anxiety	☐ none	☐ yes	Who?	Treated?
Depression	☐ none	☐ yes	Who?	Treated?
ADHD	☐ none	☐ yes	Who?	Treated?
Behavior Problems	☐ none	☐ yes	Who?	Treated?
Schizophrenia	☐ none	☐ yes	Who?	Treated?
Substance Abuse	☐ none	☐ yes	Who?	Treated?
Suicide	☐ none	☐ yes	Who?	Treated?
Abuse	☐ none	☐ yes	Who?	Treated?

Academic/Educational history:

Current school_____ Current Grade_____

Special education placement? _____ yes _____ no If yes, in what area? _____

Has the school performed psychological testing? _____ yes _____ no _____ don't know

Is there an IEP (Individual Education Plan)? _____ yes _____no _____ don't know

Has your child's teacher expressed any concerns about your child's social, emotional, behavioral, or academic functioning? If yes, please explain

_____

_____

Substance Use:

Tobacco use: __None __ Suspected__Known to use currently

Type:_____ Amount: _____ How often:_____

Drug use: __None __Suspected __ Known to use currently ___ Recovering

Type: _____ Amount: _____ How often: _____

Alcohol: __ None __ Suspected __Known to use currently ___ Recovering

Type:_____ Amount:_____ How often:_____

Caffeine use: __ None __ Amount and Frequency:_____

Child's Interests/Activities:

_____

_____

_____

Child's Strengths:

_____

_____

_____

Current Legal Concerns: _____ yes _____ no If yes, explain: _____

_____

Religious/Spiritual Affiliation(s): _____ ____none ____prefer not to answer

Is there anything you would like to discuss with the therapist/psychologist without your child present? If so,explain:_____

_____

Parent/Legal Guardian Signature: _____ Date: _____

_____ _____

Reviewing Therapist Date

_____ _____

Supervising Psychologist (if applicable) Date

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Children's Behavioral Health • 1000 North 90th Street • Omaha, NE 68114 • 402-955-3900

Patient Last Name	Patient First Name	MI
Patient DOB	Patient Gender ☐ Male ☐Female	PCP/Physician
Patient Home Address		Preferred Telephone

Behavioral Health Care Treatment Agreement

The patient named above ("the Patient") will receive behavioral health care at Children's Behavioral Health ("Children's"), a department of Children's Hospital & Medical Center. In my capacity as the parent/legal guardian/legally authorized representative of the Patient (or as an adult patient or emancipated minor patient), I understand and agree to the following:

a. I understand that the Patient's trust in his/her behavioral health care providers ("Providers") is essential to the therapeutic process. To further that trusting relationship, I agree that:
   1. Discussions between Children's Providers and the Patient may be held confidential from me unless the Patient is deemed to be at risk of harming him/herself or others;
   2. I will not request that any of the Patient's treatment records be released to my attorney; and
   3. My attorney will not request any Children's Providers' testimony or deposition in the event of a legal dispute.

b. I understand that Children's Providers do not perform custody evaluations, so should custody or placement of the Patient ever be an issue, I should seek an independent custody evaluation from a psychologist who specializes in forensic evaluation.

c. I understand that the Patient's other parent (unless his/her parental rights have been terminated or otherwise limited by law) and/or another legal guardian or legally authorized representative of the Patient may (1) be given the same information and recommendations regarding the Patient that I am given and (2) make an appointment to review the Patient's treatment records to address any questions or concerns that might arise.

d. I understand that the Patient's Providers must report any evidence of possible child abuse or neglect to the appropriate authorities.

_____

Signature of Parent with Legal Custody, Legal Guardian, Adult Patient or Emancipated Minor Patient, or Other Legally Authorized Representative of Patient ***Date***

_____

Print Name ***Relationship to Patient***

_____

Signature of Provider ***Print Name*** ***Date***

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Electronic-Mail Awareness Consent Form

Electronic Mail communications involving and/or containing information about the patients care will be maintained in the patient's medical record (chart). This would apply to communication from the patient, parent/guardian or treatment provider. In addition please be aware that our computer system does not permit an out of office notice to be posted for non internal users. We acknowledge that emailing the treatment provider directly is not a secure form of communication, and we agree and accept the use of direct email communication with the treatment provider. Finally, email should not be used for emergency communication.

I have read the above statement and understand and accept the contents.

_____ _____

Parent/Guardian Signature Date

_____ _____

Patient Signature (19 or older) Date

_____

Patient Name (Print)

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CATEGORIES FOR CONSENTING TO TREATMENT

Please (✓) check which one applies:

____ Biological parents are married; each parent can consent to treatment of child

____ Adoptive parents are married; each parent can consent to treatment of child

____ Parents are divorced with joint custody decree providing each parent can consent to treatment for child

____ Parents are divorced with decree granting custody and the right to consent to treatment for child to: __ mother __ father

____ _____is (are) child's legal guardian(s) and each can consent to treatment of child

____ Other (please explain): _____

_____

Patient Name

_____

Parent/Legal Guardian Signature

_____

Relationship to Patient

_____

Date