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.
Pretreatment Questionnaire- Adult

We know children.

Patient Name ___________________________ Birth date ________ Today’s date ________________

Completed by ___________________________ Relationship to Patient ____________________________

Primary concern for which treatment is sought: ________________________________________________

______________________________________________________________________________________

Individually living in your home:

Name ___________________________ Age ________ Relationship ____________________________
Name ___________________________ Age ________ Relationship ____________________________
Name ___________________________ Age ________ Relationship ____________________________
Name ___________________________ Age ________ Relationship ____________________________

Previous mental health treatment:

Mo/Yr _______ Provider ________________ Treatment __________________________ Outcome ________________
Mo/Yr _______ Provider ________________ Treatment __________________________ Outcome ________________

Developmental history:

Complications at birth or in early childhood? __ yes __ no If yes, please explain: __________________________
Approximate age walked ______ Approximate age talked ______

Educational history:

__ Did not complete high school __ Completed high school __ Some college
__ College graduate __ Graduate school __ Highest degree: __________________________

Employment:

__ Currently employed. Where? __________________________
__ Not employed. Have training in __________________________
__ Disabled from work. Explain: __________________________
Interests/activities:

Current legal concerns:  yes  no  If yes, please explain

Medical Issues:
Hospitalizations/dates:  None  Other:

Serious injuries/dates:  None  Other:

Last visit to doctor  Doctor’s name:
Allergies:

Medications (prescribed and over-the-counter):
Medication  Dosage  Prescribing physician
Medication  Dosage  Prescribing physician
Medication  Dosage  Prescribing physician

Substance Use:
Alcohol:  None  Suspected  Confirmed  Type:  Frequency:
Illicit Drugs:  None  Suspected  Confirmed  Type:  Frequency

To my knowledge, the above information is complete and correct:

Signature of patient  Date

Provider use only:

I have reviewed this information and believe that it is complete to extent that the client is able to provide:

Signature of provider  Date
## 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 Section

<table>
<thead>
<tr>
<th>Signature of Parent with Legal Custody, Legal Guardian, Adult Patient or Emancipated Minor Patient, or Other Legally Authorized Representative of Patient</th>
<th>Date</th>
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<tr>
<th>Print Name</th>
<th>Relationship to Patient</th>
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<tr>
<th>Signature of Provider</th>
<th>Print Name</th>
<th>Date</th>
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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)