BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

New Patient Information – Child/Adolescent

Please note: *The child/minor needs to be accompanied by the biological/natural parent, the adoptive parent, or the legal guardian appointed by the court. Court documents stating parenting plans, adoption or legal guardianship must be presented at the time of the appointment. In the absence of the above at the time of the appointment, the visit needs to be rescheduled for when the parent or guardian is present.*

PATIENT INFORMATION

Name _____

Address _____

City, State, ZIP _____

Home Phone # _____ Cell Phone # _____

Parent/Guardian Email _____

Birth Sex _____ Identifies as _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not-Hispanic or Latino ☐ Decline to Answer

Primary Language _____

Social Security Number _____

Interpreter needed? ☐ Yes ☐ No

If yes, language _____

Parent/Guardian Name _____ Phone _____

Address _____ City/State/Zip _____

Parent/Guardian Name _____ Phone _____

Address _____ City/State/Zip _____

MEDICAL PROVIDERS/PHARMACY INFORMATION

Primary Care Physician _____ Phone _____

Address _____ City/State/Zip _____

Pharmacy _____ Phone _____

Address _____ City/State/Zip _____

Mail Order Pharmacy _____ Phone _____

Address _____ City/State/Zip _____

Referring Physician _____ Phone _____

Address _____ City/State/Zip _____

If you would like clinical notes from today's visit sent to your referring physician, please ask the front desk about completing a Release of Information form.

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

City/State/Zip _____ Relationship _____

Release to Family Members (Optional)

Please list any additional family members with whom we may speak about appointment scheduling and billing, including making payments on the account:

Name _____ Relationship _____

Name _____ Relationship _____

Please note all clinical information pertaining to the patient is strictly confidential. If you would like us to disclose any clinical information to a family member, you must complete a separate Release of Information form available at the front desk.

PRIMARY INSURANCE

Insurance Name _____ Phone _____

Policy Number _____ Group Number _____

Subscriber Name _____ Subscriber DOB _____

Patient Relation to Subscriber _____ Employer _____

Subscriber SSN _____

SECONDARY INSURANCE

Insurance Name _____ Phone _____

Policy Number _____ Group Number _____

Subscriber Name _____ Subscriber DOB _____

Patient Relation to Subscriber _____ Employer _____

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

ADMINISTRATIVE AND FINANCIAL AGREEMENTS

We strongly feel that all patients deserve the very best behavioral health care that we can provide. Further, we feel that everyone benefits when our financial policies are clearly explained. Please read below carefully to understand our policies. Your signature at the bottom of the page indicates that you agree to them, as is required prior to receiving care.

Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility. You are directly and fully responsible for charges not covered by your insurance company. Payment to us is not contingent on any settlement, judgment, or insurance payment by which you may eventually recover. If your insurance company fails to pay your balance in full, or there is not payment made within 60 days, you are responsible to pay for services rendered. If you fail to make timely payment on your account, you will be responsible for costs of collection, including filing fees and reasonable attorney's fees. There will be a $25 charge on all returned checks.

NON-COVERED SERVICES AGREEMENT

Our staff will make every effort to assist you with your insurance company to ensure that your treatment is authorized and you receive the maximum reimbursement to cover the cost of your treatment. In the event your insurance company refuses to authorize services as medically necessary, or refuses to pay for services for any other reason, you will be responsible for all charges associated with your care and payments for services rendered.

CANCELLATION POLICY

In the event you have to cancel or reschedule an appointment, we require a 24-hour advanced notice. If authorized, we do attempt to make a confirmation call for said appointment, but this is a courtesy and not a guarantee. In the event we do not receive a 24 hour notice, you will be charged a $65.00 cancellation fee. Please make every effort to be on time for your appointment. I**f you are late for your appointment, it may have to be rescheduled based on the provider's availability.** We realize that emergencies do occur, but ask that you place a call to the office and let us know.

MEDICAL RECORDS AND FORMS FEES

Medical records may be requested and sent if authorized by your provider. Our fees are compliant with Florida Statutes and are $1 per page up to 25 pages and .25 cents per page thereafter. There is not a charge to send your records to another physician's office. Patients are responsible for fees if not paid within 60 days by requesting party. If you need a letter from the doctor or forms completed, there will be a fee for these services. The fees vary and we will notify you of the exact cost depending on your specific need (minimum of $25). These services may take up to 15 working days to complete due to the high volume of requests.

NOTICE OF PRIVACY PRACTICES

I accept this as notification that I may request a copy of the privacy practices as required by HIPAA at any time during my treatment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize this office to release any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my treatment. We require a 3 working day notice for all prescription requests. In regards to refills, we accept requests from you and/or your pharmacy. We will submit a request to your provider and if approved by your provider, the refill will be called in to your pharmacy on file on your behalf or printed for pickup during business hours.

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

PRESCRIPTION POLICY

We require a 3 working day notice for all prescription requests. In regards to refills, we accept requests from you and/or your pharmacy. We will submit a request to your provider and if approved by your provider, the refill will be called in to your pharmacy on file on your behalf or printed for pickup during business hours.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I give consent for this office to bill my insurance company directly for services rendered. I authorize payment directly to this provider of any insurance benefits otherwise payable to me. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to BBH for which these fees are payable

AUTHORIZATION OF APPOINTMENT REMINDERS

I authorize this office to send me reminder text messages 2-3 days before my appointment. I will notify the front desk staff if I would prefer phone calls or would like to opt out.

AUTHORIZATION TO OBTAIN MEDICAL HISTORY FROM ESCRIPT

I authorize BBH to obtain my medication history from a national database (eScript) for the purpose of continued treatment. I understand that this authorization will remain in effect for one year, but that I may revoke it at any time in writing. The revocation will not apply to information already released. I understand that I am not obligated to authorize this and that my ability to obtain treatment is not dependent upon such authorization. I understand that if I want eScript to release my medication history to anyone but BBH, eScript may charge a fee.

I understand that although federal or state law may prohibit BBH from re-disclosing information, eScript may not have any control over BBH, and therefore, cannot guarantee that BBH will not re-disclose such information. I release eScript and BBH from any and all liability related to their reliance on this authorization and the release of information based on this authorization.

CONSENT FOR MEDICAL PHOTOGRAPHY

I authorize BBH to take my photograph (or the person for whom I am the legal representative of guardian). I understand that the photograph will be placed in the medical record to be used for purposes of identification and treatment. The photograph will become the property of BBH and will be maintained in accordance with its policies. I release BBH from any and all liability which in any way arises out of their obtaining, in good faith, such photographs. I also waive any right that I may have to direct the use of the photographs.

I have read and understand the above policies and agree to them in full.

_____ _____ _____

Patient (or legal guardian) signature Date Time

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

CONSENT TO TREAT

I consent to examination and treatment by my mental health provider(s) on staff at Baptist Behavioral Health. I affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below represents that they are the parent, legal guardian, or person other otherwise allowed by law to consent to the examination and treatment of the patient.

_____ _____ _____

Patient (or legal guardian) signature Date Time

TREATMENT AGREEMENT

As a licensed mental health professional with Baptist Behavioral Health (hereinafter "BBH"), I am committed to offering the highest quality services to you. In order to accomplish this goal, I have found it helpful to clearly state what I have to offer and what I need from you as a client. Before signing, please carefully read this agreement and the commitments that are required. Mutual participation is necessary for a successful working relationship. Please feel free to discuss this agreement with me at any time.

It is important to schedule appointments that appropriately reflect your needs (e.g. how often). I recognize that this is sometimes a difficult task. Thus, I will make every effort to schedule our appointments at times that are mutually convenient. I realize that occasionally you may need to speak with me by telephone. I understand that, at times, pressing issues may arise that must be dealt with before our scheduled appointment. Please make every effort to call during working hours and I will attempt to be as available as possible to you. In times of crisis, if I am unavailable, BBH will make every reasonable effort to have one of our other providers accessible to help you. We are available after hours by calling our office number at 904-376-3800. As a licensed provider, I am also personally and legally committed to your safety and well-being, as well as the safety and well-being of those around you. Therefore, I am legally and ethically bound to consider breaking confidentiality if I believe you are an imminent danger to yourself and/or someone else (e.g. suicidal, child/elderly abuse, sexual abuse, homicidal threat, etc.). I am also bound to provide records to a court of law if subpoenaed. As an ethical clinician, I am committed to fully utilize my personal and professional skills to maximize the possibility of a positive treatment outcome. However, since the therapeutic process is an inexact science, no guarantees are stated or implied regarding actual outcome. Throughout the course of therapy, I will initiate discussion of our progress toward treatment goals and suggest revisions in the intervention techniques when needed. I understand my right to terminate participation at any time, for any reason, without any penalty.

_____ _____ _____

Patient (or legal guardian) signature Date Time

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

CHILD/ADOLESCENT HEALTH QUESTIONNAIRE

Treatment Issues – Please check any issues you have experienced or would like to address at this time:

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Suicidal thoughts
- ☐ Self-injurious behavior
- ☐ Anger problems
- ☐ Eating problems
- ☐ Sleeping problems
- ☐ Alcohol/drug problems
- ☐ Anxiety problems
- ☐ Panic attacks
- ☐ Phobias
- ☐ Nail biting
- ☐ Concentration
- ☐ Memory problems
- ☐ Sexuality
- ☐ Medications issues
- ☐ Family of origin issues
- ☐ Parenting concerns
- ☐ School issues
- ☐ Learning disabilities
- ☐ ADHD
- ☐ Impulsivity
- ☐ Temper tantrums
- ☐ Other: _____

PRIOR PSYCHOLOGICAL HISTORY	YES	NO
Has your child had direct contact with any social agency, clinic, etc.?	☐	☐
Previous intelligence, achievement, or psychological testing?	☐	☐
Has your child been hospitalized for psychiatric reasons?	☐	☐
Has your child been treated for an alcohol or drug problem?	☐	☐
Has your child received outpatient mental health services in the past?	☐	☐

If "YES" to any of the above please provide the following information

Treatment Facility or Office	Treatment Provider	Duration of Services	Reason for Services

ABUSE/NEGLECT HISTORY

Is there a history of physical or sexual abuse ☐ Yes ☐ No _____

Is there a history of neglect ☐ Yes ☐ No _____

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY

Please select any conditions that your child may have experienced in the past or is currently experiencing.

- ☐ Febrile seizures
- ☐ Epilepsy
- ☐ Staring spells
- ☐ Meningitis or encephalitis
- ☐ Dizzy Spells
- ☐ Asthma or allergies
- ☐ Autoimmune Diseases
- ☐ Head banging
- ☐ Repetitive/stereotypic movements (e.g. hand flapping)
- ☐ Clumsiness
- ☐ Loss of consciousness
- ☐ Headaches
- ☐ Abdominal pains/vomiting
- ☐ Sinus Issues
- ☐ Failure-to-thrive
- ☐ Malnutrition
- ☐ Thyroid problems
- ☐ Lead poisoning/toxic ingestion
- ☐ Sleep walking/talking
- ☐ Tics/twitching
- ☐ Diabetes
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cardiovascular problems
- ☐ Reproductive system problems

Please list all prescription or over-the-counter medications that your child is currently taking, or include a medication list with this form:

Medication name	Dosage	Date	Reason	Doctor	Results

In the last 2 weeks, how many times has your child missed any of their medications?

☐ None ☐ 1-2 days ☐ 3-5 days ☐ most days

Please list any allergies/sensitivities that your child has: _____

_____

_____

SURGICAL HISTORY:

Please list any surgeries your child has had:

Name of Surgery	Date	Outcome

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

NAMES OF PATIENT'S SIBLINGS & AGES

_____ _____

_____ _____

_____ _____

_____ _____

Who lives in the home? _____

FAMILY MEDICAL HISTORY

Please select any conditions that you may have experienced in the past or are currently experiencing.
Please check if anyone in the family has a history of any of the below. Indicate who in the space next to the condition.

- ☐ Depression _____
- ☐ Bipolar disorder _____
- ☐ Sleep disturbances _____
- ☐ Suicide attempts _____
- ☐ Eating disorder _____
- ☐ Anger problems _____
- ☐ Alcohol/drug abuse _____
- ☐ Dementia _____
- ☐ Cancer _____
- ☐ Asthma or allergies _____
- ☐ Headaches _____
- ☐ Psychosis _____
- ☐ Other_____ _____
- ☐ Other_____ _____
- ☐ Anxiety problems or phobias _____
- ☐ Panic attacks _____
- ☐ Seizures _____
- ☐ Tic disorder _____
- ☐ OCD _____
- ☐ Reproductive system issues _____
- ☐ ADHD _____
- ☐ Learning disabilities _____
- ☐ Cardiovascular Issues _____
- ☐ Diabetes _____
- ☐ Abdominal Pains/Vomiting _____
- ☐ Other_____ _____
- ☐ Other_____ _____
- ☐ Other_____ _____

FAMILY SUBSTANCE ABUSE & SOCIAL HISTORY

Please provide information about your child's use of the following substances:

	Yes	No	Type	Amount	Frequency
Tobacco					
Alcohol					
Caffeine					
Vitamins/Herbs					

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

EDUCATIONAL HISTORY

Please bring a copy of school records (report cards, disciplinary notes, educational plans) to the visit.

Current school _____ Grade _____

School address _____

Placement: ☐ Regular ☐ Resource ☐ Special education

Any grades that were skipped or repeated: _____

Has an IEP and/or 504 plan been used: ☐ Yes ☐ No

Are you requesting academic accommodations for your child? ☐ Yes ☐ No

If yes, please state what you are requesting _____

Teachers report problems in:

☐ Reading
☐ Spelling
☐ Arithmetic
☐ Other_____
☐ Attention/Concentration
☐ Behavior/Social adjustment
☐ Writing
☐ None

SOCIAL BEHAVIOR

Does your child:

Get along well with children	☐ Yes	☐ No	Have friends	☐ Yes	☐ No
Get along well with adults	☐ Yes	☐ No	Keep friends	☐ Yes	☐ No
Understand gestures	☐ Yes	☐ No			
Recognize emotions (anger, sadness, etc.)	☐ Yes	☐ No			
Have problems with peer pressure	☐ Yes	☐ No			
Have problems with bullying	☐ Yes	☐ No			
Have a sense of humor	☐ Yes	☐ No			

GESTATIONAL PERIOD

Were there any health problems during the pregnancy: ☐ Yes ☐ No

_____

Were any substances or medications used during the pregnancy: ☐ Yes ☐ No

_____

Was delivery: ☐ Vaginal ☐ C-Section ☐ Spontaneous ☐ Induced

Was baby: ☐ Full term ☐ Pre term

BAPTIST Behavioral Health

Patient Name: _____

Date of Birth: _____

DEVELOPMENTAL HISTORY

Motor: Age sat alone _____ crawled _____ stood alone _____ walked alone _____

Was your child slow to develop motor skills or awkward compared to siblings/friends

(e.g. running, skipping, climbing, biking, playing ball)? ☐ Yes_____ ☐ No

Handedness: ☐ Right ☐ Left ☐ Both

Anyone else in family with same handedness: ☐ Yes ☐ No

Was physical therapy ever necessary: ☐ Yes ☐ No

If Yes, When: _____

Was occupational therapy ever necessary: ☐ Yes ☐ No

If Yes, When: _____

SPEECH/LANGUAGE

Age spoke first word _____ Put 2-3 words together _____

Speech delays/problems (e.g. stutters, difficult to understand)? ☐ Yes ☐ No

If Yes, Explain: _____

Was speech/language therapy ever necessary: ☐ Yes ☐ No

If Yes, When: _____

Besides English, my child is fluent in: _____

Was child slow to:

Learn the alphabet: ☐ Yes ☐ No

Count: ☐ Yes ☐ No

Name colors: ☐ Yes ☐ No

☐ N/A

TOILETING

Age when toilet trained: _____

Current or past problems with any of the below?

Bedwetting: ☐ Past ☐ Current

Daytime urine accidents: ☐ Past ☐ Current

Soiling: ☐ Past ☐ Current

☐ N/A