## CHILD/ADOLESCENT INTAKE (18 years & younger)

Child's Name: _____ MI._____ Last _____

Date of Birth _____ Home phone _____ Work Phone _____

Address: _____

☐ Male ☐ Female Child's Primary Care Physician _____

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***Mother's Name*** _____ ☐ Biological ☐ Step-mother ☐ Adopted

Address: _____

Phone/Home _____ Work _____ Cell _____

***Father's Name*** _____ ☐ Biological ☐ Step-mother ☐ Adopted

Address: _____

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 _____

The client (child) resides with : _____

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

**IN CASE OF EMERGENCY PLEASE CONTACT:**

Name: _____ Phone _____

Relationship to Client: _____ Work _____

**INSURANCE INFORMATION**: Please give us your insurance card to copy for our records.

Name of Employer _____

Employee's Name: _____ DOB of Employee _____

**CHILD & ADOLESCENT SURVEY** DATE _____

Client 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? _____

School _____

Home _____

Day care _____

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? (circle those that were successful)

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 you 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 you 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 (mom, dad, siblings, grandparents...?) _____

_____

_____

Location and relationship of extended family _____

_____

_____

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

_____

How easily does you 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 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? _____

At what age did child: sit up_____ stand alone_____ walk alone _____

use words _____ Use sentences _____

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 _____

Approximately how much time did toilet training take from onset to completion?

Less than 1 month _____ 1-2 mos _____ 2-3 mos _____ More than 3 mos _____

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 _____

_____

Allergies _____

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? NO

_____

_____

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

_____

6. Does your child have any allergies? 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 control problems...at night? 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? YES NO

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

**EDUCATIONAL HISTORY**

Current School_____ Repeated grade? _____

Teacher _____ Current 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 ARD 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
_____ 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.) | | $ 60.00 ½ hr. |
| School Conferences or Meetings (mtg/travel time+mileage @.50 per mi.) | | $125.00/hr. |
| Court Testimony or Depositions (mtg/travel time+mileage @.50 per mi., retainer required) | | $300.00/hr. |
| Emergency/Crisis Evaluation (individual) | | $275.00/hr. |
| Letter Writing | | $ 60.00 per ½ hr. |
| Records Fees | | $ .76 per page |
| Preparation Fee | | $ 22.88 + postage |
| Fail To Keep Appointment | | $ 60.00 |
| Return Check Fee | | $ 25.00 |
| Record Review | | $ 60.00 per ½ 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-payments as outline in my current policy. I agree to make the required payment at the time of service. I also agree to pay in full all balances owed to Chester River Behavioral Health, LLC should my insurance company not make payment. I agree to supply information regarding changes in my insurance coverage, mailing address and phone numbers. I will be responsible for any balances due as a result of my failure to advise.

**Payment for services for minors**: The amount due for each session must be paid in full upon arrival. Chester River Behavioral Health 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, arrangement for payment must be made in advance.

**I am aware that cancellations of appointments (except for situations which would be considered emergencies) require 24 hours advance notice. If I am unable to cancel with adequate notice or if I fail to keep a scheduled appointment, I agree to pay a $60.00 fee for the missed session. 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, attorney's fees, and court costs. If any suit must be filed to collect an unpaid balance on an account, patient, and/or guarantor, agrees that such suit may be brought in courts of Kent or Queen Anne's Co., MD, 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 receive from Chester River Behavioral Health, 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 its agent. I agree to this information being released if my insurance provider or its agent requests it for authorization of treatment sessions and/or for payment.

I have been provided a copy, I have read, and am aware of and agree to the terms described in the Maryland Notice Form regarding the 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** **Date** **Printed Name**

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**Witness**

# 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 released 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_____

Date_____

**Please sign and return**

# CHESTER RIVER BEHAVIORAL HEALTH LLC

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and progress.

I,_____
Name Birth date

authorize_____, to release protected health information related to my
Provider Name
evaluation and treatment to:_____.
PCP Name PCP Phone

I saw_____on_____for_____.
Patient Name Date Reason/Diagnosis

If you have any questions or would like to discuss this case in greater detail, please call me at:_____.
Phone Number

_____
Provider Signature Licensure

### PATIENT RIGHTS

- You can end this authorization (permission to use or disclose information) any time by contacting our administrative staff.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this authorization may be re-disclosed by the recipient and no longer protected by law.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to disclose your information.

**Patient Authorization**

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

PLEASE CHECK ONE

_____ To release any applicable mental health/substance abuse information to my primary care physician.
_____ To release only medication information to my primary care physician.
_____ I DO NOT give my authorization to release any information to my primary care physician.

_____
Patient Signature Date Signature of Authorized Representative Date

If signed by Authorized Representative, describe relationship to patient:: _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records, the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (43 CFR Part2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.