Behavioral Health Choices

1. Child Intake Form:

Child's Name:_____DOB:_____

Father's Name:_____

Address:_____ City:_____

State: _____ Zipcode:_____

Cell Number:_____Home:_____Work:_____

Email address:_____

Mother's Name:_____

Address:_____City:_____

State:_____Zipcode:_____

Cell:_____Home:_____Work:_____

Email address:_____

Parents are
___ Married
___ Divorced
___ Not married

Primary Insurance:_____

Primary Insured's Name:_____ Primary Insured's DOB:_____

Insurance ID:_____ Group Number:_____

2. Patient Consent for Use and Disclosure of Protected Health Information

____I hereby give my consent for Behavioral Health Choices to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Behavioral Health Choices describes such uses and disclosures more completely.)

____I have the right to review the Notice of Privacy Practices prior to signing this consent. Behavioral Health Choices reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Behavioral Health Choices.

____With this consent, Behavioral Health Choices may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

____With this consent, Behavioral Health Choices may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

____With this consent, Behavioral Health Choices may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Behavioral Health Choices restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

____By signing this form, I am consenting to allow Behavioral Health Choices to use and disclose my PHI to carry out TPO.

____I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Behavioral Health Choices may decline to provide treatment to me.

_____

Signature of Patient (ages 14 to 18) Print name Date

_____

Signature of Parent/Guardian(ages 13 and younger) Print name Dat

Behavioral Health Choices

3. Authorization To Release Form For Insurance Purposes

Patient Name:_____D.O.B:_____

Address:_____

Information is being released to (Your Insurance Company Name):

_____

Specific information is to be released:

Copies of psychiatric intake evaluation, summary of treatment progress.

Purpose for releasing information:

Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services.

I understand that my records are protected under a section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state of federal regulations. I also understand that I may revoke this consent at any time except for the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(specification of dates, event, or condition upon which this consent expires)

I, (patient age 14 to 18)_____ hereby authorize Behavioral Health Choice to release the information stated above.

_____

Patient Signature (ages 14 to 18) Date

I, (parent/guardian)_____hereby authorize Behavioral Health Choices to release the information stated above.

_____ _____ Parent /

Guardian Signature Date

Prohibition On Redisclosure: Alcohol and Drug Abuse information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal regulations (42 CFR, Part 2) prohibits you from making any further disclosures of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is 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.

Behavioral Health Choices

4. Patient Bill of Rights

1.You have a right to be treated with dignity and respect.

2.You have the right to not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability or marital status.

3.You have the right to easily access care in a timely fashion. Behavioral Health Choices established a linkage agreement with the Horsham Clinic. Our after hours coverage is outlined on our website as well as in the informed consent form you are signing.

4.You have the right to participate in the development and review of your treatment plan.

5.You have the right to choose the services in which you participate based upon information about the treatment procedures, costs, risks, rights and responsibilities.

6.You have the right to refuse treatment or service unless ordered by the court to participate.

7.You have the right to end service at any time without any moral, legal or financial obligation except pay for those services already received.

8.You have a right to be informed about the rules that will result in discharge from the program if violated, participate fully in decisions regarding your discharge from program and receive advance notice regarding the proposed discharge, unless your behavior threatens the well being of another person.

9. You have the right to refuse to take medications, if you chose.(You should not discontinue taking medications suddenly without first discussing the possible dangers with your psychiatrist.)

10. You have the right to not be subjected to verbal, sexual or emotional abuse, harsh or unfair treatment.

11. You have a right to examine your records and request a copy of them. Limited portions of your records can be withheld from you if your health care provider believes that seeing specific information would be harmful to you.

12. You have the right to have information about you released to other agencies only by your written permission authorizing a release of specific information.

13. You have a right to make complaints, having them heard, get a prompt response, and not receive any threats or mistreatment as a result.

14. You have the right to contact the Office of Civil Rights or the Pennsylvania Human Relations Department about any complaints you may have regarding discrimination.

_____ _____

Signature of Patient (ages 14 to 18) Date

_____ _____

Signature of Parent/Guardian Date

Behavioral Health Choices

5. Patient Responsibilities:

Participation in Treatment:

I understand that in order for treatment to be helpful, I must participate on a regular basis as agreed upon between myself and my health care provider. Emergency situations do happen, and it is my responsibility to notify my provider and/or the office if I'm unable to attend the scheduled session as soon as possible but notice needs to be given at least 24 hours before the scheduled session and 48 hours for an initial appointment.
In order to receive the best possible care, I will let my health care provider know if there are any changes to my health or changes in the medications I am prescribed by other physicians.

Fee Agreement:

I agree to pay the cost per session of treatment unless covered by insurance. I have been made aware of the private rates that Behavioral Health Choices charges when no insurance coverage is available. Late cancellations or "no shows" (less than 48 hours notice for initial evaluations and 24 hours for follow up appointments) will be billed at a rate of $ 170 for initial evaluations and $ 75 for follow-up appointments. We charge $ 25 for medication refills outside office hours. Payments are expected at the time of service which includes patients with insurance deductibles. Behavioral Health Choices charges additional fees for letters to be typed or for copies of medical records. Please ask our staff for current rates.
Scheduling with my therapist:

If my therapist elects to schedule/reschedule via text, it is my clear understanding that this communication is for scheduling purposes only. In case of an emergency I will follow the instructions as outlined in
"Information and Consent to treatment".

_____

Signature of patient (ages 14 to 18) Date

_____

Signature of Parent/Guardian Date

Behavioral Health Choices

6. Information and Consent to Treatment

We are pleased that you have selected Behavioral Health Choices. This document is designed to ensure that you understand our professional relationship with you.

I. Client Agreement

All the clinicians at Behavioral Health Choices are professionally trained, experienced and licensed by their professional regulatory boards. The model of treatment typically involves weekly psychotherapy, and less frequent medication management visits. Some clients need only a few sessions to achieve their goals, while others may require longer periods of treatment based on complexity and severity of problems.

Although your sessions may be very intense and psychologically intimate, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your therapist to social gatherings, offer gifts, or ask them to relate to you in any way other than in the professional context of your counseling sessions. We will keep anything you say to your therapist/psychiatrist confidential with the following exceptions: (1) you direct us to tell someone else, (2) we determine that you are a danger to yourself or others, or (3) we are ordered by a court to disclose information. We are also mandated to report suspected child abuse.

By signing this form, you are consenting to have your therapist discuss your case from time to time with your psychiatrist for collaboration and consultation.

_____ _____

Signature of patients ages 14 to 18 Date

_____ _____

Signatures of mother and father/all guardians for patients ages 3 to 13 Date

- Therapy sessions are approximately 45 minutes in duration, medication management sessions vary in length but are approximately 15 to 20 minutes.

Therapy/treatment can be terminated by both the client or the clinician under the following circumstances:

I. If either the client or the clinician believes therapy/treatment is not being helpful to the client; 2) If the client is not complying with those elements of therapy/treatment essential for progress; 3) If the client's behavior or the behavior of someone in a relationship with the client is harmful or potentially harmful to other clients or the clinician.

Legal Issues:

II. If you are in the midst of any type of legal issues such as litigation, a dispute with your employer, separation or divorce, please inform your therapist immediately. Please be aware that in custody cases, we typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved. Authorizations to release information regarding legal matters must be on Behavioral Health Choices letterhead. Please remember that Behavioral Health Choices has no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your card numbers or co-pay changes, please let us know.

Cancellation/Office Hours:

III. In the event that you will not be able to keep an appointment, you **must** notify us **24 hours in advance** for follow up appointments and **48 hours for initial evaluations.** If we do not receive such advance notice, you will be responsible for paying a **$75.00 cancellation fee** for a missed therapy or medication follow up appointment and **$170.00 for an initial visit**. Our offices are open during regular business hours and we have a linkage agreement with the Horsham Clinic after hours.

Emergencies:

IV. Behavioral Health Choices has formed a linkage agreement with the **Horsham Clinic** for after hours and emergency care. Patients who experience a clinical emergency after hours should call 800-237-4477, the designated 24/7 Crisis and Referral Center at the Horsham Clinic.

Please note that adolescent and child clients living outside of Montgomery County should contact their designated 24/7 Crisis Center for Children, or contact their nearest emergency room. The Bucks County Mental Health Crisis Center for Children can be reached by calling ACCESS at 877-435-7709.

Social Networking:

V. It is the policy of Behavioral Health Choices that employees do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites such as Facebook, Twitter, and other similar sites. This applies to non-active and active clients for a minimum of two years after discharge.

Disability Forms:

VI. Please be advised that providers at Behavioral Health Choices are not able to fill in paper work for disability claims. You might need to approach your primary care provider to help you with this.

I acknowledge that the initial appointment is a consultation only and does not establish a treatment relationship. If a clinician at Behavioral Health Choices deems that I would not benefit from BHC's outpatient program, he/she will give recommendations as to what treatment would be more appropriate. My signature below indicates that I grant consent for Behavioral Health Choices to provide psychological services and counseling to myself and/or minor members of my family.

My signature also indicates that I have received information about how I can express any dissatisfaction.

_____ _____

Signature of patients 14 to 18 Date

_____ _____

Signatures of mother and father/all guardians Date

<u>Insurance Assignment</u>

VI. I the undersigned, have insurance coverage with _____ and assign directly to Behavioral Health Choices all medical benefits. If my insurance company does

not cover fees for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Behavioral Health Choices to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that all services provided which are not covered by insurance will be billed separately.

Patient Signature (ages 14 to 18)_____Date:_____

Parent/Guardian Signature_____Date:_____

To Parents of Adolescents:

VII. I understand the need for confidentiality between my son/daughter and his/ her therapist and that confidentiality will be maintained unless the therapist determines that my son/daughter is a danger to self or others.

_____ _____

Parent/Guardian Signature of patients ages 14 to 18 Date

Behavioral Health Choices

7. Payments for Services

We are asking all patients to leave a valid credit card number on file for payment should the insurance company determine that a deductible or coinsurance was required at the time of visit. Insurance companies have various plans and it is not always possible to determine the copayment accurately at the time of visit. Please note that Behavioral Health Choices will only bill you for the service or part of the service if your insurance company determines that you are liable for the payment. We also charge your credit card for missed appointments which is **$ 75 for follow-ups** and **$ 170 for initial evaluations. We charge $ 25 for medication refills outside office visits**.

___Master card ___Visa card

Credit Card Number:_____
Expiration date:_____
3 digit code on the back of your card:_____
Credit card holder's name_____

By singning I acknowledge that I am responsible for any copayments or deductibles as required by my insurance policy.

_____
Parent Signature

_____
Please Print Name Date

Behavioral Health Choices

7. Consent to Release Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medications. I may revoke this consent at any time except to the extent that the action has been taken in reliance up on it and that in any event this consent shall expire 12 months from the date of signature, unless another date has been specified.

I, _____D.O.B:_____for the purposes of coordinating care

authorize Behavioral Health Choices to release information indicated in the"consent" portion of this form to

Name of Primary Care Physician:_____
Office name:_____
Street address:_____City_____
Phone:_____

Consent

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 12 months from the date of signature unless another date is specified. I have read and understood the above information and give my consent.

Please check the following:

__to release any applicable mental health/substance abuse information to my primary care physician

_____

Patient's Signature (ages 14 to 18) Date

_____

Parent/Guardian Signature Date

Consent to communicate with Guardians/Parents

I, Patient (age 14 to 18)_____

give my consent to the clinicians at Behavioral Health Choices to communicate with my parents/ guardians verbally or in writing about my behavioral health concerns.

_____

Patient Signature (age 14 to 18) Date:

Consent to communicate with an outside therapist (if applicable)

I, Patient (age 14 to 18)_____

I, Parent (of patients ages 3 to 14)_____

give my consent to the clinicians at Behavioral Health Choices to communicate with my therapist not practicing at BHC

_____

Name:

_____

Address:

_____

Tel number:

_____

Patient Signature (age 14 to 18) Date

_____

Parent/Guardian Signature Dat

Depression questionnaire children ages 11 to 17

	Not at all	several days	more than half the days	nearly every day
1. Feeling down, depressed, irritable, or hopeless?	X	X	X	X
2. Little interest or pleasure in doing things?	X	X	X	X
3. Trouble falling asleep, staying asleep, or sleeping too much	X	X	X	X
4. Poor appetite, weight loss or overeating?	X	X	X	X
5. Feeling tired, or having little energy?	X	X	X	X
6. Feeling bad about yourself-or feeling that you are a failure, or that you have let yourself or your family down?	X	X	X	X
7. Trouble concentrating on things like school work, reading, or watching TV?	X	X	X	X
8. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you were moving around a lot more than usual?	X	X	X	X
9. Thoughts that you would be better off dead, or hurting yourself in some way?	X	X	X	X