

## Crosspointe Family Services--Patient Demographics

Please fill out front and back of Form.

<b>Patient Information</b>	Last Name: _____ First: _____ Middle: _____
	Street Address: _____
	City: _____ State: _____ Zip: _____ Cell Phone: _____
	Soc. Sec. #: _____ Date of Birth: _____ Age: _____ Sex: <b>M F</b>
	E-mail: _____ Marital Status: _____

<b>Custodian/Guardian Information FOR YOUTH 18 or Younger</b>	<b>Who does the client live with?</b> Name: _____
	Address: _____ Phone: _____
	<b>Does this person have the legal authority to consent for treatment?</b> Yes No
	If Yes, circle one: <b>Biological/Adoptive Parent Legal Guardian Foster Parent IDHW Caseworker</b>
	If No, who has this authority? Name _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____	
<b>**We are unable to see a youth client without the consent of the legal parent/guardian/custodian.</b>	

<b>Other Information</b>	Occupation: _____	Preferred Language: _____
	Employer: _____	Communication Needs: _____
	Employer Address: _____	Spouse: _____
	Work Phone: _____	<b>Race:</b> Circle Answers <b>Ethnicity:</b>
	Referring Source: _____	1 American Indian/Alaskan Native 1 Hispanic
		2 Asian 2 Non-Hispanic
	What are we seeing you for? _____	3 Black or African American
		4 Native Hawaiiin/ Pacific Islander
5 White or Caucasian		
6 Prefer not to answer		

<b>Responsible Party Information</b>	Responsible Party: _____ D.O.B. _____ Soc. Sec. #: _____
	Address: _____ Phone: _____
	Relationship: _____ Occupation: _____
	Employer: _____ Work Phone: _____

<b>Insurance Information</b>	Policy Holder: _____ D.O.B. _____
	Medical Insurance: _____
	Address: _____ Phone: _____
	City: _____ State: _____ Zip: _____ E-mail: _____
	Policy #: _____ Medicaid #: _____
Group #: _____ Medicare # _____	

<b>Emergency Information</b>	IN CASE OF EMERGENCY CONTACT (Person <u>NOT LIVING</u> with patient).	
	Contact Name: _____	Relationship to Patient: _____
	Address: _____	Phone: _____
	City: _____ State: _____ Zip: _____	Cell Phone: _____

Insurance payments are considered a method of reimbursement to the insured participant for fees paid to Crosspointe and is not a substitute for payment. We do not accept this amount as "payment in full" (unless otherwise restricted by law or agreement with your insurer). **IN ORDER TO MAINTAIN COSTS WE ASK THAT OUR CHARGES AND COPAYS BE PAID AT THE TIME OF EACH VISIT.** In the event the account is turned over for collection, you agree to pay all collection fees and/or legal fees including attorney fees.

I hereby assign all medical and mental health benefits to which I'm entitled including Medicaid, Medicare, private insurance and other health plans to Crosspointe Family Services. This assignment will remain in effect until revoked by me. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment for services I received via Facsimile, hard copy, or electronically.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



### **ACKNOWLEDGEMENT**

I acknowledge that I have read, reviewed, and was offered a copy of the following Crosspointe Terms and Conditions for Treatment.

1. Notice of Privacy Practices
2. Informed Consent for Treatment
3. Participants Rights and Grievance Procedure
4. Patient Authorization for Third Party Payor Reimbursement of Provider and Other Verification
5. Other Terms and Conditions

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Witness: \_\_\_\_\_

07/2018

# CROSSPOINTE FAMILY SERVICES

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

List all **ALLERGIES** you have: \_\_\_\_\_  
\_\_\_\_\_

List all **MEDICATIONS** you take: \_\_\_\_\_  
\_\_\_\_\_

List all Herbal **Supplements** and **Vitamins** you take: \_\_\_\_\_  
\_\_\_\_\_

List any previous significant **TRAUMA**: \_\_\_\_\_  
\_\_\_\_\_

Indicate any **SURGERIES** you have had:

- |  |                                  |                                     |                                |
|--|----------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Appendix          | <input type="checkbox"/> Hernia  | <input type="checkbox"/> Uterus     | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Gallbladder       | <input type="checkbox"/> Tonsils | <input type="checkbox"/> Tubes Tied | <input type="checkbox"/> None  |
| <input type="checkbox"/> List Other: _____ |                                  |                                     |                                |

Do **You** have any of the the following medical problems?

- |  |                                      |                                 |                                   |
|--|--------------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Asthma/Lung         | <input type="checkbox"/> Arthritis   | <input type="checkbox"/> AIDS   | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart       | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Mood swings | <input type="checkbox"/> HIV    |                                   |
| <input type="checkbox"/> List other: _____   |                                      |                                 |                                   |

Do any of the following Medical problems run in your **FAMILY**?

- |  |                                    |                                      |                                   |
|--|------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Asthma/Lung         | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart     | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Cancer   |
| <input type="checkbox"/> List Other: _____   |                                    |                                      |                                   |

**Do you Smoke?**  Yes  No  
Packs per day? \_\_\_\_\_ Years? \_\_\_\_\_

**Do you drink Alcohol**  Yes  No  
Type and Number of drinks per day \_\_\_\_\_

**Do You now or have you ever used or taken any drugs not prescribed by a doctor?**

- No  
 Yes Please list: \_\_\_\_\_

Do You use smokless tobbaoco/chew?  Yes  No

**Check any you have had recently or concerns:**

- |   |  |
|---|--|
| <input type="checkbox"/> Low Energy Level     | <input type="checkbox"/> Excessive Sleeping    |
| <input type="checkbox"/> Excessive Energy     | <input type="checkbox"/> Weakness              |
| <input type="checkbox"/> Restlessness         | <input type="checkbox"/> Recent Vision Changes |
| <input type="checkbox"/> Excessive Sadness    | <input type="checkbox"/> Trembling/Shaking     |
| <input type="checkbox"/> Irritability         | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Difficulty breathing  |
| <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Over Use of Laxatives |
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Aggression            |
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Easily Distracted     |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Itching               |
| <input type="checkbox"/> Victim of Crime      | <input type="checkbox"/> Hair Pulling          |
| <input type="checkbox"/> Excessive Anger      | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Self Injury          | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Insomnia              |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Anxiety               |
| <input type="checkbox"/> Numbness             | <input type="checkbox"/> Suicidal Thoughts     |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Nightmares            |
| <input type="checkbox"/> Hallucinations       | <input type="checkbox"/> Excessive Worry       |
| <input type="checkbox"/> Mood Swings          | <input type="checkbox"/> Panic                 |
| <input type="checkbox"/> Excessive Hunger     | <input type="checkbox"/> Unexplained Pain      |
| <input type="checkbox"/> Weight Gain          | <input type="checkbox"/> Weight Loss           |
| <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Change of Libido      |
| <input type="checkbox"/> # of Pregancies:     | <input type="checkbox"/> # of Children:        |

**Who is your primary care doctor/provider?**

**When was your last vist with your primary provider?**

**Who else manages your medical and/or behavioral health care: Provider Name/City**

**Comments:**



# CROSSPOINTE

FAMILY SERVICES

At Crosspointe Family Services we want to ensure that we are coordinating your care with all of your providers. Please tell us who is involved in your medical and behavioral health care. We believe that working together as a care team on your behalf provides the greatest care to you.

**Patient's Name** \_\_\_\_\_ **B-Day** \_\_\_\_\_

Provider Name \_\_\_\_\_ Specialty \_\_\_\_\_

Facility Name \_\_\_\_\_ City \_\_\_\_\_

Provider Name \_\_\_\_\_ Specialty \_\_\_\_\_

Facility Name \_\_\_\_\_ City \_\_\_\_\_

Provider Name \_\_\_\_\_ Specialty \_\_\_\_\_

Facility Name \_\_\_\_\_ City \_\_\_\_\_

Provider Name \_\_\_\_\_ Specialty \_\_\_\_\_

Facility Name \_\_\_\_\_ City \_\_\_\_\_

Thank you for your help!

If you have any questions or concerns about how we coordinate your care or how we use the information please contact:

Mark Gritton  
208-736-7090

We respect and protect your patient rights.

# Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301  
Office: (208)-736-7090 Fax: (208)-736-7089

## MEDICAL-Release and/or Exchange of Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian/Foster Parent Name: \_\_\_\_\_

**I DECLINE TO RELEASE ANY INFORMATION TO:** \_\_\_\_\_

### **I authorize:**

Name/Title: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

*(Initial either or both as needed.)* \_\_\_\_\_ to release PHI information to: \_\_\_\_\_ to obtain PHI information from: \_\_\_\_\_

### **Crosspointe Family Services**

**1363 Fillmore St**

**Twin Falls, ID 83301**

**Office: (208)-736-7090 Fax: (208)-736-7089**

#### **A. The confidential Protected Health Information (PHI) to be released: (Initial)**

<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Coordination of Care Communication
<input type="checkbox"/> Last Office Progress Note	<input type="checkbox"/> Pharmacy/Medication List	<input type="checkbox"/> Entire Medical Record
<input type="checkbox"/> Progress Notes: from _____ to _____	<input type="checkbox"/> Medication List(s)	<input type="checkbox"/> Parent/Guardian Communication
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Comprehensive Diagnostic Assessment	<input type="checkbox"/> Care Plan
<input type="checkbox"/> Other: _____		

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

#### **B. Effective date of authorization:**

This authorization takes effect the day that you sign it and terminates on: \_\_\_\_\_ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

\_\_\_\_\_  
Participant/Guardian/Foster Signature Date

\_\_\_\_\_  
Witness Signature Date

# Crosspointe Family Services

1363 Fillmore St, Twin Falls, ID 83301  
Office: (208)-736-7090 Fax: (208)-736-7089

## Behavioral Health-Release and/or Exchange of Protected Health Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian/Foster Parent Name: \_\_\_\_\_

### **I authorize:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

*(Initial either or both as needed.)* [ ] to release PHI information to: [ ] to obtain PHI information from:

**Crosspointe Family Services**  
**1363 Fillmore St**  
**Twin Falls, ID 83301**  
**Office: (208)-736-7090 Fax: (208)-736-7089**

### **A. The confidential Protected Health Information (PHI) to be released:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Psychiatric test results          | <input type="checkbox"/> CBRS (PSR) Treatment Plans   | <input type="checkbox"/> Speech therapy reports               |
| <input type="checkbox"/> Psychological Test results        | <input type="checkbox"/> GAIN Assessment              | <input type="checkbox"/> Case Management Plans                |
| <input type="checkbox"/> Diagnostic Assessments            | <input type="checkbox"/> Therapy Progress             | <input type="checkbox"/> Billing Information                  |
| <input type="checkbox"/> Developmental assessments         | <input type="checkbox"/> Medical History/Physical     | <input type="checkbox"/> Aftercare Plans/Reports              |
| <input type="checkbox"/> Clinical Treatment Plans          | <input type="checkbox"/> Occupational therapy reports | <input type="checkbox"/> Coordination of Care Communications* |
| <input type="checkbox"/> Behavioral health therapy reviews | <input type="checkbox"/> Pharmacy/Medication List     | <input type="checkbox"/> Appointment Communications#          |

\*Any verbally released information regarding treatment. #Any verbal information regarding scheduling appointments/no shows.  
Other: \_\_\_\_\_

Such information may be freely exchanged by the above-designated parties in writing (by fax, electronic mail, or other electronic file transfer mechanisms), by postal delivery, in person, or by telephone, but such exchange is limited to the agencies or people listed and to necessary information related to care and treatment of the client, unless otherwise specified. I release the parties involved from all liability arising from such exchange of PHI records. I accept full responsibility for any and all action or consequences that may directly or indirectly result from the release of my PHI. I understand that this "Release of PHI" is intended to allow me to provide my informed consent for an exception to my confidentiality and the protection of my privacy guaranteed under federal law, including, but no limited to, the Federal Privacy Act (P.L. 93-579), the Freedom of Information Act (P.L. 93-502), Code of Federal Regulations (42, Part 2), and HIV records under Public Health Law article 27-F.

### **B. Effective date of authorization:**

This authorization takes effect the day that you sign it and terminates on: \_\_\_\_\_ or one year from the date it is signed.

I understand that I have a right to revoke this authorization at any time. I can refuse to sign this authorization. I need not sign this authorization in order to receive treatment. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Crosspointe Family Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as law provides my insurer with the right to contest a claim under my policy.

Participant/Guardian/Foster Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

## **NO SHOW/MISSED APPOINTMENT POLICY**

**Definitions:**

**No Call/No Show:** *ANY missed appointment that isn't canceled with at least 24 hours' notice.*

- If you call the day of your appointment, it is considered a No Call/No Show.
- If you do not show up for your appointment, it is considered a No Call/No Show.
- If you are more than 10 minutes late for your appointment, it is considered a No Call/No Show.

**Adequate Communication:** *Calling AT LEAST 24 hours in advance to cancel or change an appointment.*

- When you call with at least 24 hours' notice, we are able to allow another client to fill your appointment.

**Emergency:** An emergency is a situation in which you have absolutely no control or choice.

- If you are in a car accident, that is an emergency.
- If you are in the emergency room or at urgent care, that is an emergency.
- If your car battery is dead when you try to start your car, that is an emergency.
- If someone in your immediate family dies, that is an emergency.

We, at **Crosspointe Family Services**, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling **208-736-7090**.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or text to you is made/attempted one (1) business day prior to your scheduled appointment. Please plan to arrive for your appointment on time.

### **PLEASE REVIEW THE FOLLOWING POLICY:**

1. If necessary, please cancel or change your appointment with at least a 24 hours' notice; there is a waiting list to see the clinicians at **Crosspointe Family Services** and, whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than 24 hours is given to cancel or change an appointment, this will be documented as a "No Call/No Show" appointment.
3. If you do not show up to the office for your appointment, this will be a "No Call/No Show" appointment.
4. After the first "No Call/No Show" appointment, you will receive a phone call or letter warning that you have broken our "No Call/No Show" policy. **Crosspointe Family Services** will assist you to reschedule this appointment, if needed.
5. After the 2nd "No Call/No Show" appointment, you will be removed from your counselor's schedule and will only be able to make a return appointment with that counselor's approval. You will not be able to make an appointment with any other clinician in our office.

**I have read and understand Crosspointe Family Services' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Crosspointe Family Services appropriately if I have difficulty keeping my scheduled appointments.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or Parent/Guardian if minor

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date



## LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

## Screen for Child Anxiety Related Disorders (SCARED)

### PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(10), 1230–6.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Directions:**

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
2. My child gets headaches when he/she am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
3. My child doesn't like to be with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
4. My child gets scared if he/she sleeps away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
5. My child worries about other people liking him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
6. When my child gets frightened, he/she feels like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
7. My child is nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
8. My child follows me wherever I go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
9. People tell me that my child looks nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
10. My child feels nervous with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
11. My child gets stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
12. When my child gets frightened, he/she feels like he/she is going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
13. My child worries about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
14. My child worries about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
15. When my child gets frightened, he/she feels like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
16. My child has nightmares about something bad happening to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
17. My child worries about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
18. When my child gets frightened, his/her heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
19. He/she child gets shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
20. My child has nightmares about something bad happening to him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP

**Screen for Child Anxiety Related Disorders (SCARED)**  
**PARENT Version—Page 2 of 2 (to be filled out by the PARENT)**

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	○	○	○	GD
22. When my child gets frightened, he/she sweats a lot.	○	○	○	PN
23. My child is a worrier.	○	○	○	GD
24. My child gets really frightened for no reason at all.	○	○	○	PN
25. My child is afraid to be alone in the house.	○	○	○	SP
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○	SC
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○	PN
28. People tell me that my child worries too much.	○	○	○	GD
29. My child doesn't like to be away from his/her family.	○	○	○	SP
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○	PN
31. My child worries that something bad might happen to his/her parents.	○	○	○	SP
32. My child feels shy with people he/she doesn't know well.	○	○	○	SC
33. My child worries about what is going to happen in the future.	○	○	○	GD
34. When my child gets frightened, he/she feels like throwing up.	○	○	○	PN
35. My child worries about how well he/she does things.	○	○	○	GD
36. My child is scared to go to school.	○	○	○	SH
37. My child worries about things that have already happened.	○	○	○	GD
38. When my child gets frightened, he/she feels dizzy.	○	○	○	PN
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	○	○	○	SC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○	SC
41. My child is shy.	○	○	○	SC

**SCORING:**

A total score of  $\geq 25$  may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder or Significant Somatic Symptoms**. **PN =**

A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of 3 for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

*The SCARED is available at no cost at [www.wpic.pitt.edu/research](http://www.wpic.pitt.edu/research) under tools and assessments, or at [www.pediatric.bipolar.pitt.edu](http://www.pediatric.bipolar.pitt.edu) under instruments.*



# CROSSPOINTE

FAMILY SERVICES

## Telehealth Informed Consent Form

I \_\_\_\_\_, consent to engaging in telehealth with Crosspointe Family Services as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications. I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Crosspointe Family Services that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth based services and care may not be as complete and in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of doxy.me, healthsafeid.com, and simplyclinical.com systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Crosspointe Family Services or its staff liable for gathering or use of client information by these service providers.



# CROSSPOINTE

FAMILY SERVICES

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

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Signature of client/parent/guardian

Date

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Printed name of client/parent/guardian

Relationship (If applicable)

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E-mail (for visit links)