Barnabas Medical Behavioral Healthcare, LLC

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A Full Service Behavioral Health Practice Specializing in the Strategic Integration of Medical and Psychological Care

Child Intake Form Date _____

Child's Name _____ Date of Birth _____ Age _____

Present Address _____ City _____ State ____ Zip _____

Permanent Address _____ City _____ State ____ Zip _____

Telephone Home _____ Work _____ Mobile _____

Social Security # _____

Name of the person(s) with whom child lives? _____

Relationship Father ____ Mother ____ Guardian ____ Other ____

Person to contact in case of an emergency _____

Address _____ Telephone _____

FAMILY INFORMATION

Mother's Name _____ Birth Date _____ Age _____

Occupation _____ Marital Status _____

Address _____

Telephone Home _____ Work _____ Mobile _____

Father's Name _____ Birth Date _____ Age _____

Occupation _____ Marital Status _____

Address _____

Telephone Home _____ Work _____ Mobile _____

Names of Brothers and Sisters including step siblings

1. _____ Age Gender
2. _____ Age Gender
3. _____ Age Gender
4. _____ Age Gender
5. Age Gender

Religious Affiliation _____ Active? ☐ Inactive? ☐

Number of times you attend religious services per month _____ Child? _____

MEDICAL INFORMATION

Child's Primary Care Provider _____ Phone _____

Is he/she currently taking any medication? If so, please list _____

Does your child have any medical conditions? Yes ☐ No ☐ If so, how do they (it) contribute to the current problem? _____

Are there any conditions (including mental health problems) in your family that may contribute? Yes ☐ No ☐ If so, please explain _____

SCHOOL INFORMATION

School attended _____ Grade _____

If your child is not in school, why not? _____

Name of Teacher _____

Has your child ever failed a grade? Yes ☐ No ☐ If so, what grade? _____

What are your child's usual grades? _____

Does your child have trouble leaving you to go to school? Yes ☐ No ☐ Does your child enjoy school? Yes ☐ No ☐

What has been your child's biggest problem at school? _____

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

How does your child get along with other students? _____

Discuss any other academic or behavioral problems your child may have at school _____

CONCERNS/PROBLEMS INFORMATION

What do you consider the main problem and how long has your child had this problem? _____

Have there been times when the problems got better or disappeared? Yes ☐ No ☐ If so, when? _____

What do you think helped? _____

Were there times when the problem was especially bad? Yes ☐ No ☐ If so, when? _____

What do you think made worse? _____

Are there other people who play a role in causing your problem? Yes ☐ No ☐ Helping your problem? Yes ☐ No ☐ Explain Briefly Below

Does your child have any *unusual* fears such as fear of darkness, dogs etc.? Yes ☐ No ☐ Please explain _____

Does your child prefer to play with children his/her Own Age ☐ Younger Children ☐ Older Children ☐

Does he/she fight with friends? Yes ☐ No ☐

Where does your child sleep? _____

PROBLEM AREAS

Problem Areas: In the following list, please place a check next to each item which indicates an area of concern to your child. Please place two checks by items which are most important (you may add comments.)

Comments

- ☐☐ Aggressiveness
- ☐☐ Bangs head
- ☐☐ Breaks the law
- ☐☐ Convulsive attacks
- ☐☐ Daydreams
- ☐☐ Family problems
- ☐☐ Fire-setting
- ☐☐ Holds breath
- ☐☐ Intellectual disability
- ☐☐ Hurts self
- ☐☐ Over sensitive
- ☐☐ Running away
- ☐☐ Screaming
- ☐☐ Sleeping problems
- ☐☐ Temper problems
- ☐☐ Unhappiness
- ☐☐ Withdrawn, lonely
- ☐☐ Other _____
- ☐☐ Depression
- ☐☐ Difficulty getting along with others
- ☐☐ Disobedience
- ☐☐ Drugs, Alcohol
- ☐☐ Eating problems
- ☐☐ Fighting
- ☐☐ Health problems
- ☐☐ Hurts others
- ☐☐ Lying
- ☐☐ Over-activity
- ☐☐ Physical complaints
- ☐☐ School problems
- ☐☐ Sexual misbehavior
- ☐☐ Slow learner
- ☐☐ Throws self at the floor
- ☐☐ Wets bed

Has your child ever had body coordination difficulties such as awkwardness in throwing a ball, riding a bicycle, frequent falling etc? Yes ☐ No ☐ If yes, describe _____

How does your child prefer to spend his/her free time? _____

What are some things you think your child does well? _____

Is this child harder to manage than other children? Yes ☐ No ☐ Explain _____

Describe how you usually discipline your child _____

Names of other persons in the household where child now lives

1. _____ Age ____ Gender ____ Relationship _____
2. _____ Age ____ Gender ____ Relationship _____
3. _____ Age ____ Gender ____ Relationship _____
4. _____ Age ____ Gender ____ Relationship _____
5. _____ Age ____ Gender ____ Relationship _____

DEVELOPMENTAL HISTORY

Pregnancy with this child was	Planned ☐ Unplanned ☐	Normal ☐ Abnormal ☐	If abnormal, please explain	_____
Mother's health during the pregnancy	Good ☐ Fair ☐ Poor ☐			
Labor and birth	Normal ☐ Abnormal ☐	If abnormal, please explain		_____
Birth weight _____ Condition at birth	Normal ☐ Abnormal ☐	If abnormal, please explain		_____
Give the approximate age in months at which the child	Sat Up _____ Toilet Trained _____	Crawled _____	Walked _____	Talked _____
Discuss any special family circumstances	_____			
Other helpful information	_____			
How did you hear about our center?	_____			

I completed the above information accurately and have read and agree to the general information and policy statements of Barnabas Medical-Behavioral Healthcare, LLC. I give my consent for services with Barnabas Medical-Behavioral Healthcare and its professional staff to include assessment, diagnosis, psychotherapy, pharmacotherapy, involvement in the treatment planning process, evaluation and testing as appropriate.

Signature _____ Date _____

Provider _____ Date _____

Medical History

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Patient Medical History

- ☐ Headache
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness/Fainting
- ☐ Peripheral Vascular Disease
- ☐ Allergies/Hay fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI Disorder
- ☐ Lactose Intolerance
- ☐ Gallbladder Disease
- ☐ Prostate Problems
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Overactive Bladder
- ☐ Frequent Urination
- ☐ Sexual/Menstrual Dysfunction
- ☐ Venereal Disease
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet fever
- ☐ Chronic rashes
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diphtheria
- ☐ Tetanus

Date _____ Patient DOB _____

Patient Name _____ Patient Signature _____

Provider _____ Parent/Guardian Signature _____

Please CLEARLY list any current medications you are taking	**Strength**	**Dose**	**Frequency**
Example- Zithromax Z-Pack	*250 mg*	*2 Pills*	*Daily*

Please list clearly any allergies as it related to medications

Example -Penicillin

Preferred Pharmacy Name _____

Phone Number _____

Address _____

Primary Care Doctor _____ Fax Number _____

Referring Provider _____ Fax Number _____

THE PROCESS OF COUNSELING

Counseling is a special, safe, healing, and respectful process wherein a trained helper works with a wounded person to reach a mutually agreed upon goal and level of functioning that reflects psychological wellbeing. We work with a broad variety of individuals with differing life stresses, coping resources and abilities.

The INTAKE is the initial session wherein the client and practitioner meet to understand the presenting concerns and develop a plan to address change. It also allows the assessment of therapeutic good fit and the ability to work together in a mutually responsible manner. This initial stage may be further refined according to circumstances and progress made. Psychological testing may be utilized to understand and define inner dynamics more fully.

Everyone is unique and life circumstances vary widely so the process and length of treatment will differ among clients (even if someone else seems to be undergoing or has experienced similar problems).

The next phase of counseling involves gaining a fuller understanding and taking ownership of the identified problem(s) and the way psychological, relational, and/or medical components work and are addressed and repaired. You will try a personalized treatment strategy with teaching, coaching, and encouragement from your professional helper.

The final stage simply involves fine tuning until you are feeling that you can take it from there (it's OK to need a few follow-ups from time to time).

THE PROCESS OF PSYCHIATRIC CARE

Similar to counseling, the process of psychiatric care also involves a collaborative relationship between the patient and provider. Psychiatric care is individualized for the unique needs of each patient; therefore, it is important to evaluate past medical and psychiatric history and overlay this with current medical and psychiatric presentation. At times, with the patient's consent, this may involve gathering information from other sources, such as family members and other medical providers. Screening tools and/or questionnaires may be utilized to aid diagnosing and gauge patient status. Lab tests are also an important component of some treatment plans, as these assist with tracking medication levels and overall response to treatment.

The goal of psychiatric care is to provide patient-centered, holistic care; therefore, the duration of psychiatric treatment and frequency of follow-up visits depends on multiple factors that are specific to each patient. On average, adult medication management follow-up appointments are initially scheduled at intervals of 3 to 4 weeks. Thereafter, the timeline between follow-up appointments increases to 3 to 4 months and expands from this point, based on the needs of the patient and type(s) of medications being prescribed. Follow-up appointments for pediatric and adolescent patients are typically scheduled at 2-week intervals, followed by 1-month med checks, and then quarterly (every 3 months). For pediatric and adolescent patients, "eyes on" care is an important factor in providing safe, high-quality care. Therefore, for these patients, if medication is prescribed for a mood or behavioral disorder, attending counseling is an important aspect of achieving long-term wellness, life-long coping skills, as well as gauging effectiveness of the current treatment plan.

CONFIDENTIALITY

All communication between you and your counselor will be held in confidence and will not be revealed to anyone, unless required by law. Information that you wish to disclose to or obtain from anyone will only be initiated with your written consent.

OFFICE HOURS AND COMMUNICATION

Our office hours vary among our counseling staff. Limited evening and Saturday morning appointments are available. Staff can typically be contacted at our Evelyn Drive office by calling (803) 216-0850 between 9:00 a.m. and 5:00 p.m., Monday through Friday. You may leave a voicemail if our line is busy or after hours. You may also ask your provider how to contact them on an individual basis.

In the event of an emergency, if we cannot be reached, please go directly to the emergency room of the hospital of your choice and continue to attempt to contact us. Prisma ER (formerly Palmetto Health) can be reached at (803)-434-4813 or dial 911.

APPOINTMENTS

Typically, your counselor will schedule to see you weekly during a standing appointment time (your time reserved just for you). However, because you may need to change your appointment from time to time, we ask that you verify your next appointment with your counselor at the end of each session. Changes in appointments can so be made by phone; priority will, however, be given to those with standing appointments.

CANCELLATION OF APPOINTMENTS

You may cancel an appointment without charge by calling 24 hours in advance. Except in cases of emergency, cancellations without sufficient notice will lead to a charge of one-half the normal fee on the first occasion all others will incur a full-fee charge. Patient insurance will not cover a cancellation/"no show" charge and you will be responsible for the balance.
Late cancellations prevent your counselor from being able to schedule this time with other clients in need. Others may request to see your counselor, perhaps in a crisis, and be turned away only to find that the scheduled appointment was missed. Two consecutive cancellations of any kind may also lead to forfeiture of your standing appointment time and the need for you to find a new time.

FEES AND PAYMENTS

We have attempted to set our fees at a reasonable level in accordance with state and national fee schedules. They are moderate in comparison with the prevailing rates in this area. In most situations the client pays only the co-pay amount and/or coinsurance amount and insurance company is billed for the remainder. We expect full payment of your portion at the time of service as well as any account balance you may have incurred from previous appointments.
We will file insurance claims as a courtesy to our clients however it is solely the responsibility of the client to notify us of any insurance changes.
You may use check, cash, and credit card for payment. There is a charge for testing, and costs vary with the individual test or tests taken.
If you are not covered by insurance and you have a limited income, you may request to be a self-pay client and we can discuss sliding scale fees. If you have questions about whether your insurance policy covers counseling services, you need to call your insurance company or agent to determine this. Our office staff is familiar with the coverage on some policies but, frankly, insurance companies can sometimes be unreliable. Since the insurance arrangement is between you and your insurance company the burden is yours to insure proper dispensation. We welcome this opportunity to serve you and look forward to working with you.

Barnabas Behavioral Healthcare LLC

Notice of Privacy Practices

This notice describes how medical, drug and alcohol and psychological related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320det seq,, 45 C.F.R. Part 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Barnabas Behavioral Healthcare LLC may not say to a person outside Barnabas Behavioral Healthcare LLC that you attend the practice, nor may Barnabas Behavioral Healthcare LLC disclose any information identifying you as a client, or disclose any other protected information except as permitted by federal law.

Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Barnabas Behavioral Healthcare LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Barnabas Behavioral Healthcare LLC can share information for treatment purposes or for health care operations. However, federal law permits Barnabas Behavioral Healthcare LLC to disclose information without your written permission in the following situations:

1. Pursuant to an agreement with a qualified service organization/ business associate
2. For research, audit or evaluations.
3. To report a crime committed on Barnabas Behavioral Healthcare LLC premises or against Barnabas Behavioral Healthcare LLC personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child abuse or neglect or domestic violence.
6. As allowed by a court order.

For example, Barnabas Behavioral Healthcare LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified services organization/ business associate agreement in place.

Barnabas Behavioral Healthcare LLC may need to share your protected health information with third party "business associates" that perform various activities such as laboratory services and billing partners. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Before Barnabas Behavioral Healthcare LLC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing at any time.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. At your request, Barnabas Behavioral Healthcare LLC will not disclose information to your health insurance plan about any services for which you have paid out-of-pocket.

Barnabas Behavioral Healthcare LLC is not required to agree to any other restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Barnabas Behavioral Healthcare LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Barnabas Behavioral Healthcare LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Barnabas Behavioral Healthcare LLC records, and to request and receive an accounting of disclosures of your health related information made by Barnabas Behavioral Healthcare LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Barnabas Behavioral Healthcare LLC Duties:

Barnabas Behavioral Healthcare LLC will not share your protected health information for marketing or fundraising purposes, nor will we ever sell your protected health information without your prior approval.

Barnabas Behavioral Healthcare LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Barnabas Behavioral Healthcare LLC is required by law to abide by the terms of this notice. Barnabas Behavioral Healthcare LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. You may access a revised version by accessing our website, or you may request a copy by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact our Compliance Officer Thomas Cromer at 803-216-0850.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You also may submit a written compliant to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer. The contact information is provided below.

Contact Officer: Thomas Cromer, Corporate Compliance Officer Telephone: 803-216-0850 Fax: 602-253-6554

Address: 409 Evelyn Drive Columbia, South Carolina 29210

Acknowledgement of Receipt of Privacy Practices

I have read, understood, and received a copy of Barnabas Behavioral Healthcare LLC Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

Signed:_____Date: _____

Printed Name: _____

Patient Care Communication Form (release of information to Primary Care Provider)

Primary Doctor/Care Provider/Referring Doctor's Name _____

Telephone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Dear _____,

Your patient, _____ has been seen by _____.

Date of initial assessment _____. Next appointment _____.

Diagnosis and or presenting problem _____

Treatment recommendations _____

Medication Issues _____

Please call if further information or clarification would be helpful,

Sincerely,

_____

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it. This release will expire 12 months after first signed.

_____ I want this information released to my Primary Doctor/Provider/Referring Doctor

_____ I DO NOT want this information released to my Primary Doctor/Provider/Referring Doctor

Patient _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____