



New Patient Welcome Packet

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TO OUR VALUED PATIENTS:

Absolutely NO SMOKING OR VAPING is allowed on our property. Thank you for your cooperation.

Welcome to Shortgrass Community Health Center, Inc. (SCHC)

We want to make your experience with us as comfortable and convenient as possible.

SCHC is a private, non-profit community health center providing comprehensive, primary, and preventative medical services to families and individuals, regardless of the ability to pay. We are striving to be a Patient Centered Medical Home (PCMH), which is an innovative program for improving primary care for our patient population. The program gives practice information about organizing care around patient needs, working in teams, and coordinating and tracking care over time.

Services provided at SCHC are medical, behavioral health, dental, vision, substance use disorder and addiction therapy, as well as 340b pharmacy. SCHC strives to be a one-stop shop for all family health needs.

SCHC strives to provide affordable quality health care to the residents of our service area. Our doctors and staff are committed to keeping you and your family healthy, at rates that you can afford. If you have medical coverage, our staff will continue to file claims to your insurance company, Medicaid, SoonerCare, or Medicare on your behalf. If you think you might be eligible for Medicaid/SoonerCare our staff will be available to help you with the process. In order to continue with our current level of services, it will be necessary to collect the necessary fee from all of our patients when services are received. This includes the co-pay from Medicare and private insurance, as well as the minimum fee for the sliding scale discount fee program.

For patients who do not have any type of medical coverage, our fees will continue to be discounted, based on family income and size. For those who qualify, a minimum fee will be charged for each service performed. (Ex: Office visit, lab, x-ray etc.) To qualify for the sliding fee discount schedule, patients are required to complete a sliding fee application annually and update information immediately if there are any changes to income or household size. Co-payments are based upon household income and family size. Proof of income will be required to evaluate the application. The application and all documentation must be submitted at first visit or you may be subject to full charges.

SCHC understands that some patients may find it difficult to pay for services when they are received. For patients experiencing sudden financial difficulties and are unable to make payment, please contact our finance department to make financial arrangements. SCHC strives to be understanding and work with patients who are faced with sudden financial hardships. SCHC is not a 'free clinic' and is fiscally responsible to maintain sound business practices and be fiscally responsible. We do believe in no patient being surprised by a bill for care and can identify what your responsibility will be for services provided at Shortgrass prior to your appointment. If you require a 'good faith estimate' prior to services, please ask the receptionist for a form to be completed with cost estimates.

Thank you for choosing us as your health care home!

CANCELLATION POLICY

Shortgrass Community Health Center, Inc. is glad you have chosen us to provide you and your family with excellent care. It is our policy to request that you make all changes or cancellations of your appointments 24 hours in advance. We understand that situations arise that may prevent you from giving us advanced notice. Please let us know as soon as possible and realize that we may have to reschedule you if you are more than 15 minutes late. This is in order to keep our providers on schedule and avoid delays for other patients. We ask all new patients to arrive at least 30 minutes prior to the appointment to complete all necessary paperwork. Multiple broken or late appointments will be noted and could result in broken appointment fees.

LOCATIONS

SCHC – Hollis Center (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment, Dental, Optometry, 340B Pharmacy, Psychiatry)
400 E. Sycamore Hollis, OK 73550
Main Phone: 580-688-2800
Fax Number: 580-688-2193
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M.-2:00 P.M.

SCHC – Altus Center (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment, Psychiatry)
101 S. Hudson Altus, OK 73521
Main Phone: 580-301-6154
Fax Number: 580-301-6163
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M.-2:00 P.M.

SCHC – Sayre Mobile (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment, Psychiatry)
1505 Watts Street, Sayre, OK 73662
Main Phone: 580-688-2800
Fax Number: 580-688-2800
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M. – 2:00 P.M.

SCHC Pharmacy
400 E. Sycamore Hollis, OK 735501
Main Phone: 580-688-2800
Fax Number: 580-688-2193
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M.-2:00 P.M.

SCHC – Granite (Coming Soon) (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment)
507 W 6th Street
Granite, OK 73547
Main Phone: 580-688-2800
Fax Number: 580-688-2193
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M. – 2:00 P.M.

BILLING, PAYMENT, and REFERRAL INFORMATION

BILLING, PAYMENT, and REFERRAL INFORMATION

SCHC's ability to remain open and provide discounted services greatly depends on our ability to collect what fees we are required to charge, even when those fees are discounted. In order to have your charges discounted if you qualify, you MUST bring proof of income at the time of visit and complete the sliding fee discount application. If this information is not provided at time of appointment, you will be charged the full price for the appointment.

BILLING AND PAYMENT

SCHC provides services billed according to patient's ability to pay. All co-payments are collected at time of check in for the appointment. After sliding fee discounts are applied to charges, the patient is responsible for paying the remaining fees, if applicable. SCHC is **not a free clinic**. We will be happy to assist any patient with a payment plan if necessary.

GOOD FAITH ESTIMATE

It is the desire of SCHC for none of its patients to be surprised with an unexpected bill. We can offer a "good faith estimate" regardless of insurance or lack of insurance to any patient who requests it. SCHC will make every attempt in that "good faith estimate" to verify if our location is in or out of network. Any patient, can, upon request ask for a good faith estimate. If, at the end of the billing cycle, the estimate was more than the patient expected, the patient may request a review or revision of their bill. It is the desire of SCHC to rectify any disputes according to billing practices and current regulatory requirements. Such disputes should be taken to the CFO/CEO for review and reconciliation.

REFERRAL SITUATIONS

SCHC is a **primary care** clinic. When a provider determines it is necessary to refer a patient to a specialist, the patient is responsible for that bill, and/or making payment arrangements with that provider. SCHC is not responsible for, nor has any control over, charges and fees occurring from referrals to other clinics.

LAB and X-RAY

Please understand that although the services that we contract for through local hospitals are discounted, SCHC has no control over the bill a patient receives for reading those results or any additional costs the hospital may charge. A hospital is required by law to have every x-ray evaluated by a radiologist, and that radiologist's bill is separate from our services. It is the patient's responsibility to pay for these additional services as required by the hospital.

SCHC contracts with Lab Corp for discounts for certain lab tests. Lab fees will not have extra reading charges. The amount the patient pays includes the entire fee for those services and is due prior to receiving the lab service.

REGISTRATION

In order to make your visit with us as smooth and quick as possible, it is necessary for you to call for an appointment. If your appointment is for a routine or follow-up visit, you will speak with staff member to schedule an appointment.

If you are calling for an urgent situation, every effort will be made to make a same day appointment with your provider or the walk-in provider.

If you get sick when SCHC is closed, please call the SCHC after – hours phone (580) 688-2800 and follow instructions provided on what actions to take:

- **If it is an emergency, please call 9-1-1**

You must make sure you bring your identification card to each visit if you are covered by Medicaid, SoonerCare, Medicare, or private insurance. Please let us know if your insurance carrier or insurance eligibility changes, or if you have a change in address, phone number(s), or other pertinent information that affects your account. Bring your children's immunization records to each of their appointments.

If you are taking medicine prescribed by another doctor, bring all medicine bottles with you to your appointment.

DISCOUNT DRUG PRICING AND MEDICATION REFILLS

DISCOUNT DRUG PROGRAM

If a patient qualifies for a free medication program, SCHC does attempt to assist patients with paperwork required so that they may receive their medication(s). It is **not** SCHC's sole responsibility to complete all necessary paperwork. The patient is expected to participate in completing certain paperwork for this service.

Due to SCHC's federally qualified status, we are able to purchase drugs at a significant discount over regular pharmacy pricing. This is based on a percentage (%) scale, therefore, when a drug costs less, there is a smaller discount. When a drug falls into the higher price range, the discount becomes much more significant. Please feel free to take our written prescription and compare prices before purchasing.

Although in most instances the 340B Discount Drug Program pricing is less, there could be instances where pricing is very close to the same at all pharmacies. Currently, the SCHC pharmacy participates in the 340B Discount Drug Program. Please ask staff for participating pharmacies.

REFILLS

You may call your pharmacy during their regular business hours to request a refill. Please have the pharmacy **FAX** therefill request to SCHC at (580) 688-2193. Please allow at least 5 business days for medication refills. If you wait until you are out of your medication, there may be a delay in refilling your prescription. Be sure to allow extra time for weekends and holidays. If you should run out of your medication on a weekend or holiday, there will be a delay in refilling your prescription until the center re-opens. Please have your pharmacy fax your refill request physician you use, and call your pharmacy prior to picking up your medication.

MEDICATION POLICY

The following policies are to ensure your safety, and our continued ability to treat you in the most effective way possible. Please read this carefully.

1. Medication must be taken only as prescribed by our physicians and you must notify our providers when medication is given to you by another person or physician.
2. Any medication that is lost, misplaced, stolen, destroyed, or finished early may be replaced at the discretion of the provider.
3. You must not share, sell, or otherwise permit others to have access to these medications.
4. All prescriptions should be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
5. The prescribing physician and staff have permission to discuss diagnostic and treatment details with dispensing pharmacists or other professionals who provide your healthcare for the purpose of medication accountability.
6. Refills will be given only during regular office hours.
7. Refills of medication will be given at the discretion of the provider. The provider may ask you to come back into the clinic for a follow-up appointment before refills are given.
8. **CLASS II** medications need to be filled by the pharmacy within 5 days of being written. If your prescription expires you must return the prescription to our office before another prescription will be issued to you.
9. You must keep your scheduled appointments in a timely manner. If you fail to appear for an appointment, your medication may not be refilled.
10. You must provide us with 24 hours' notice to cancel an appointment. If you fail to provide this notice, you may be subject to the consequences listed in #9 above.
11. Random urine drug screens and/or pill counts may be requested. Presence of unauthorized substances, abnormal results or an inaccurate pill count may result in discontinuation of your controlled medications including, but not limited to, opioid analgesics.

Your health care team at SCHC is dedicated to your safety and good health. This policy is designed to ensure your safety and to help us and you comply with the standards of good medical care, as well as state and federal laws.

Patient Rights and Responsibilities

All persons receiving services from Shortgrass Community Health Center, Inc. shall retain and enjoy all rights, benefits, and privileges the laws and constitution of the State of Oklahoma and the United States of America guarantee, except those specifically lost through due process. In addition, all persons shall have the right guaranteed by the Substance Abuse Client's Bill of Rights, unless an exception is specifically authorized by these standards or an order of a court of competent jurisdiction. Each Client/Consumer shall be notified of these guaranteed rights at admission. Should the Client/Consumer cannot understand the language in the Bill of Rights, an oral explanation shall be given in the language that the person can understand. Each person served by Shortgrass Community Health Center, Inc. can expect:

1. To be treated with respect and dignity from personnel who protect, promote and respect human dignity.
2. The right to be safe, sanitary and humane living or treatment environment.
3. The right to a humane psychological environment that protects him/her from harm, abuse, neglect, and/or exploitation.
4. To be provided services in an environment which provides reasonable privacy, promotes reasonable privacy, promotes personal dignity, and provides the opportunity for improved functioning.
5. The right to receive services or appropriate referral without discrimination as to race, color, age, gender, marital status, sexual orientation, religion, spiritual values, national origin, degree of disability, handicapping condition, legal status, and/or the ability to pay for services.
6. To never be neglected/and/or sexually, physically, verbally, or otherwise abused, harassed, humiliated or punished.
7. The right to be provided with prompt, competent, appropriate services and an individual treatment plan.
8. To be afforded the opportunity to participate in the treatment planning and consent, or refuse to consent to the proposed treatment unless these rights are abridged by a court on competent jurisdiction or in emergency situations defined by law.
9. The right to permit family members or significant others to be involved in their treatment and treatment planning.
10. The right to have their records treated in a confidential manner within 42 CFR part 2 and HIPAA regulations.
11. The right to review their records according to the policies and procedure set forth by Shortgrass Community Health Center, Inc. that are in accordance with State and Federal Laws including 42 CFR Part 2 and HIPAA regulations.
12. The right to refuse to participate in any research project or medical experiment without specific informed consent as defined by law and that such refusal shall not affect the services available to the person served.
13. The right to request the opinion of an outside medical or psychiatric consultant, at the expense of the person served.
14. The right to assert grievances with respect to any alleged infringement of these stated rights or any other granted rights.
15. The rights to never be retaliated against or subject to any adverse conditions or treatment services, solely or partially because of having asserted any of the person served rights listed in this document.
16. The right to have their funds managed in an ethical and appropriate manner that prohibits fiduciary abuse.
17. The right to mechanisms that will facilitate access and/or referrals to legal services, advocacy services, self-help groups, guardian, and conservators.
18. The right to be informed that services can be refused and that there could be consequences to refusal of services.
19. The right to an expression of choice of release of information.
20. The right of choice of concurrent services.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable Federal and State Law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy Practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/03 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using this information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and other healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By State Law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you \$0.83 for each page up to thirty (30) and \$0.63 for each page after thirty, a \$19 administrative fee to locate and copy your health information and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. You must make your request in writing. Your request must specify the alternative means or locations and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on a website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 or 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 complaint 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 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 with the U.S. Department of Human Services.

Privacy Office: Shortgrass Community Health Center Administration
400 East Sycamore, Hollis, OK 73550
Telephone: (580) 688-2800
Fax: (580) 688-2193

CONSUMER NOTICE OF HEALTH INFORMATION PRACTICES (HIPAA)

General Information

Information regarding your healthcare, including payment for healthcare, is protected by two (2) federal laws: The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) 42, U.S.C. S1320d Confidentiality Law 42, U.S.C. 290dd-2 C.F.R. Part 2. Under these laws, SCHC, may not say to a person outside of SCHC that you attend the program or clinic, nor may SCHC disclose any information identifying you as an alcohol or drug abuser, or any patient, or disclose any other protected information except as permitted by federal law.

SCHC must obtain your written consent before it can disclose information about you for payment purposes. For example, SCHC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you also sign a written consent before SCHC can share information for treatment purposes or healthcare operations; however, federal law permits SCHC to disclose information without your written permission in the following instances:

1. Pursuant to an agreement with a qualified service organization/business associate.
2. For research, audit, or evaluation.
3. To report a crime committed on SCHC’s premises or against SCHC’s personnel.
4. To medical personnel for medical emergency.
5. To appropriate authorities to report suspected child and elder abuse or neglect.
6. As allowed by court order.

For example, SCHC can disclose information without your consent to obtain legal and financial services, or to a medical facility to provide healthcare to you, as long as there is a qualified service/organization/ business associate agreement in place. Before SCHC 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.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. SCHC is not required to agree to any restrictions you request, but if it does agree 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 at an alternative location. SCHC 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 healthcare information maintained by SCHC except to the extent that the information contains counseling notes or information compiled for use in a civil, criminal, or administrative hearing or in other limited circumstances. Under HIPAA, you also have the right, with some exceptions, to amend healthcare information maintained in SCHC’s records, and to request and receive an accounting of disclosures of your health related information made by SCHC during the past six (6) years prior to your request. You also have the right to receive a paper copy of this notice.

SCHC Duties

SCHC 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. SCHC is required by law to abide by the terms of this notice. SCHC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Such changes will be communicated to present clients through provision of a copy of the revised notice. Former clients making appropriate requests will be provided a copy of the updated notice at the time of request.

Complaints and Reporting Violations

You may complain to SCHC and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. Such complaints should be pursued through the established SCHC grievance procedures. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States District Attorney in the district where the violation occurs.

PATIENT CENTERED MEDICAL HOME (PCMH) AGREEMENT

Shortgrass Community Health Center, Inc. (SCHC) wants to be YOUR Medical Home. Our goal at SCHC is to provide patient centered care to all its patients. Patient centered care means your medical provider, Health Care Team, patient and families work together to provide quality care to YOU. We do this through patient and family communication where the needs and preferences of the patient are communicated to your SCHC Health Team. Your SCHC Health Care Team may include your medical provider – a doctor, nurse practitioner, or physician’s assistant and your nurse, dietician, lab, x-ray, dentist, optometrist, pharmacist and behavioral health specialist. In turn we will listen to these needs and focus their education and training to make sure YOU get good quality health care.

Our plan:

SCHC and the patient/parent will achieve this patient centered care based on these items that we agree upon.

- SCHC will provide quality health care to the best of our ability and knowledge in a safe environment.
- Patients and their families have the ability to ask questions and voice concerns through an open channel of communication with our Health Team.
- The patient/parent is honest in the history of symptoms. Your Health Team is open and honest in relating the diagnosis and related treatment. It is important for the patient/parent to disclose all symptoms or medical problems at the time of treatment.
- The patient/parent is agreeable with your treatment plans. SCHC will provide clean and understandable instructions.
- SCHC will provide patient with enough time during their office visit to make sure the medical problem is understood and the treatment plan is thoroughly explained. Both the patient/parent and your Health Team will respect one another’s time.
- The patient/parent will pay for their share of the services rendered not covered by their insurance at the time of the office visit. It is the patient/parent responsibility to know their insurance benefits.
- SCHC offers same day appointments for acute care and allots reasonable times for follow-up, preventative care and disease management appointments.
- SCHC may refer patient to a specialist or suggest certain tests/procedures that are not done in the office but instructions will be given for any referral. It is the patient/parent responsibility to find out if the specialist is covered by their insurance.
- SCHC is not responsible for costs for patient specialty care or tests/procedures recommended by our providers.
- SCHC will make the referral; however, it is the responsibility of the patient/parent to follow-up with the referral and understands the insurance coverage for the specific referral.
- SCHC will give results of lab/x-ray tests by calling and/or mailing the patient/parent. The patient/parent should call the office if not notified about test results in an appropriate time frame.
- The patient/parent shall do their best to participate in health habits and lifestyles.
- SCHC may provide educational health information. The patient/parent can use this information and ask questions if needed.
- The patient/parent should keep their appointments; a missed appointment takes up time that another patient could use.
- The patient/parent should arrive on time for their scheduled appointment. SCHC in turn will work to stay on schedule.
- SCHC will respect the patient/parent individually. We will not make judgments based on race, religion, gender, gender identity, age or disability.
- SCHC will respect patient/parent privacy. Medical information will not be shared with anyone unless it is vital for treatment, payment or health care operations, you give us permission, or it is required by law or court order.
- SCHC has computer prescription programs with most pharmacies. Prescriptions are sent to your specified pharmacy electronically, otherwise, a printed prescription will be provided.
- This agreement that describes your SCHC Health Care Team relationship with YOU has been given to and received by a patient/parent for his or her Health Team member today.



Shortgrass Community Health Center

2026 Sliding Scale Discount Schedule

Category	Slide	S1	S2	S3	S4	S5
% of Federal Poverty Level (FPL)	<= 100%	101 - 125 %	126 - 150%	151 - 175%	176 - 200%	
Patient Nominal Fee	Medical/BH/Vision/Psych	\$10	\$20	\$30	\$40	\$50
	Dental	\$20	\$30	\$40	\$50	\$60
	Enabling Services	\$1	\$2	\$3	\$4	\$5
Family Size						
1 Annual (Up to)	\$15,960	\$19,950	\$23,940	\$27,930	\$31,920	
Monthly	\$1,330	\$1,663	\$1,995	\$2,328	\$2,660	
Weekly	\$307	\$384	\$460	\$537	\$614	
Hourly	\$8	\$10	\$12	\$13	\$15	
2 Annual (Up to)	\$21,640	\$27,050	\$32,460	\$37,870	\$43,280	
Monthly	\$1,803	\$2,254	\$2,705	\$3,156	\$3,607	
Weekly	\$416	\$520	\$624	\$728	\$832	
Hourly	\$10	\$13	\$16	\$18	\$21	
3 Annual (Up to)	\$27,320	\$34,150	\$40,980	\$47,810	\$54,640	
Monthly	\$2,277	\$2,846	\$3,415	\$3,984	\$4,553	
Weekly	\$525	\$657	\$788	\$919	\$1,051	
Hourly	\$13	\$16	\$20	\$23	\$26	
4 Annual (Up to)	\$33,000	\$41,250	\$49,500	\$57,750	\$66,000	
Monthly	\$2,750	\$3,438	\$4,125	\$4,813	\$5,500	
Weekly	\$635	\$793	\$952	\$1,111	\$1,269	
Hourly	\$16	\$20	\$24	\$28	\$32	
5 Annual (Up to)	\$38,680	\$48,350	\$58,020	\$67,690	\$77,360	
Monthly	\$3,223	\$4,029	\$4,835	\$5,641	\$6,447	
Weekly	\$744	\$930	\$1,116	\$1,302	\$1,488	
Hourly	\$19	\$23	\$28	\$33	\$37	
6 Annual (Up to)	\$44,620	\$55,775	\$66,930	\$78,085	\$89,240	
Monthly	3,718	4,648	5,578	6,507	7,437	
Weekly	\$858	\$1,073	\$1,287	\$1,502	\$1,716	
Hourly	\$21	\$27	\$32	\$38	\$43	
7 Annual (Up to)	\$50,040	\$62,550	\$75,060	\$87,570	\$100,080	
Monthly	\$4,170	\$5,213	\$6,255	\$7,298	\$8,340	
Weekly	\$962	\$1,203	\$1,443	\$1,684	\$1,925	
Hourly	\$24	\$30	\$36	\$42	\$48	
8 Annual (Up to)	\$55,720	\$69,650	\$83,580	\$97,510	\$111,440	
Monthly	\$4,643	\$5,804	\$6,965	\$8,126	\$9,287	
Weekly	\$1,072	\$1,339	\$1,607	\$1,875	\$2,143	
Hourly	\$27	\$33	\$40	\$47	\$54	
	*	\$5,680	\$5,680	\$5,680	\$5,680	\$5,680
IMPORTANT: *For Family Units over 8, add the amount shown for each additional family member.						

Welcome to Shortgrass Community Health Center

The amount that you will be responsible for paying will be determined using a Sliding Scale Discount Schedule which is based on your total income as it relates to the Federal Poverty Level (FPL) Guidelines for this year. The sliding scale discount schedule is included in this notice.

Documentation of income and number in household must be provided to the Shortgrass Community Health Center business office to determine the eligibility and amount of discount for services to be provided.

ALL PATIENTS WILL BE SEEN REGARDLESS OF ABILITY TO PAY.

A nominal fee of \$10 is requested for services in medical, behavioral health, and vision clinics and \$20 for services provided in dental clinics for patients at or below the 100% FPL. All other patients will have a copay or minimal fee based upon their insurance carrier or their annual income.

Routine lab services are offered on a sliding scale basis but not included in the nominal fee.

Any attempt to falsify information relating to income or other eligibility requirements is a violation of federal law and is subject to prosecution.

NO PATIENT WITH INCOME GREATER THAN 200% FPL IS ELIGIBLE FOR THE DISCOUNT.

The Shortgrass Community Health Center Sliding Scale Discount Schedule is based on the current annual Federal Poverty Level (FPL) guideline and is updated in the EMR by the billing manager.

Application for Sliding Fee

Shortgrass Community Health Center offers patients a discount on their medical bills if they qualify for our sliding fee scale. The discount is based on the **GROSS** income of **ALL** members of the household and the number of members in the family. If you want to apply for this discount we need income verification. **Proof of income is required.**

(Examples: most recent pay stub, prior year's W-2 forms, tax returns, bank statement showing deposits, letter of income from employer, attestation letter from someone not a household member, self-attestation letter.)

Please list ALL family members: (*Frequency = Weekly, Biweekly, Bimonthly, Monthly, or Annual*)

Name	Date of Birth	Income	Frequency

**** Patients applying for the sliding fee program are obligated to contact SCHC if their income or household status changes, or if they become eligible for insurance. Patients must update information on an annual basis to remain on the sliding fee program.**

AFFIDAVIT

By signing below, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verify my income level is truthful. I understand that I have 30 days to provide proof on income or I will be responsible for promptly paying the full charge of all visits.

APPLICANT SIGNATURE _____ **DATE** _____

Sliding Scale Discount (FOR OFFICE USE ONLY)

Total household WEEKLY income _____ Total # household members _____

Total household BIWEEKLY income _____

Staff calculations

Total household BIMONTH income _____

Total household MONTHLY income _____

Total household ANNUAL income _____

VALID from: _____ TO _____
(month/day/year) (month/day/year)

(Authorized Office Staff Signature)

Income Category: <=100% 101-150% 151-200% over 200%

Sliding fee calculator completed:

Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, SCHC will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our finance office.

- I hereby assign, transfer, and set over to SCHC all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.
- I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of SCHC.
- I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

Patient/Guardian Signature

Date

Notice of Privacy Practices

I have been given, read, and understand the Notice of Privacy Practices of SCHC.

I have refused my copy of the Notice of Privacy Practices.

Patient/Guardian Signature

Date

Witness Signature

Date

ACKNOWLEDGMENT OF RECEIPT OF SCHC WELCOME PACKET

Please initial beside each item that you have received in writing and understand the items contained in the welcome packet. If you at any time have questions, please ask for assistance from our front desk employees.

- Cancellation Policy
- Locations
- Billing, Payment and Referral Information and Registration
- Discount Drug Pricing and Medication Refills
- Medication Policy
- Patient Rights and Responsibilities
- Notice of Privacy Practice
- Consumer Notice of Health Information Practices (HIPAA)
- Patient Centered Medical Home Agreement (PCMH)
- SCHC Sliding Fee Scale Application
- SCHC Sliding Fee Scale

Patient or Patient's Representative Signature

Date

Please Print Your Name

Patient's Name

Representative's Relationship to Patient

Verification Signature – SCHC Staff

Date

For Office Use only

Patient # _____

Client Name: _____

Date of Birth: _____

Shortgrass Community Health Center

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Receiving

Disclosing

Receiving

Disclosing

Name, Title _____

Name, Title _____

Site Address _____

Site Address _____

Phone _____

Phone _____

Assessment Treatment Plan Other Clinical Documentation Testing Behavioral Report

Discharge Information Other Information Pertinent to: _____

IE: dental care, medical care etc.

The Purpose of This Request is:

This authorization will expire on: _____ (must be updated after 365 calendar days) OR when the following event occurs: Upon discharge if before the year expiration.

Treatment is not contingent on signing this release

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions and other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. **I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. My revocation will not affect any action taken in reliance on the authorization before the revocation.** I understand that, if the receiver of information is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by state and federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

**In compliance with CFR 42, part 2, § 2.22 and O.S 43A, section 1-102, 1-103
Confidentiality of Patient Records**

The confidentiality of patient records maintained by this program is protected by State and Federal law and regulations. Generally, the program may not say to a person outside of the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

- 1) The patient consents in writing;
- 2) The disclosure is allowed by a court order; or
- 3) The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation.

Violation of the State and Federal law and regulation by a program is a crime. Suspected violations may be reported to appropriate authorization in accordance with State and Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or Federal laws and regulations do not protect any who works for the program or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

“The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). (63 O.S. P 1-1502(B)”

Non-contingency statement: I understand that my failure to sign this form will not result in the withholding of services.

Client Signature (if client is 14 or older) _____

Date _____

Parent/Guardian Signature (if under 18 or in custody) _____

Date _____



New Patient Registration Form

As a Federally Qualified Health Center, SCHC is required to collect demographic information regarding the patients we serve to support our clinic funding. The information you provide is confidential. Please check 'Not Reported/Refused' if you do not wish to answer a specific question. Thank you for choosing SCHC as your health care provider.

Section 1: Patient Information

First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____

Date of Birth: _____ SSN: _____ Sex: M F Marital Status: Single Married Widowed

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Primary Phone: _____ Home Work Cell

Primary Language: English Spanish Sign Language Other _____ Translator needed

Employment status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Not Reported/Refused	Education: <input type="checkbox"/> Student <input type="checkbox"/> High school <input type="checkbox"/> Undergraduate <input type="checkbox"/> Higher <input type="checkbox"/> Not Reported/Refused
---	--

Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other _____ <input type="checkbox"/> Not Reported/Refused	Ethnicity: <input type="checkbox"/> Non-Latino/Non-Hispanic <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Not Reported/Refused <input type="checkbox"/> Other
--	---

Are you a (please check all that apply)....? Veteran Migrant Farm Worker Seasonal Farmworker Homeless/unhoused

Income Category	1	2	3	4	Referring to the table, please list the number of members in your household & income category: List # of Family Members: _____ Please check the income category for your household: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Decline to disclose
Family Size	Annual Income (Up to)	Annual Income (Up to)	Annual Income (Up to)	Annual Income	
1	\$15,650	\$23,475	\$31,300	\$31,300 or greater	
2	\$21,150	\$31,725	\$42,300	\$42,301 or greater	
3	\$26,650	\$39,975	\$53,300	\$53,301 or greater	
4	\$32,150	\$48,225	\$64,300	\$64,301 or greater	
5	\$37,650	\$56,475	\$75,300	\$75,301 or greater	
6	\$43,150	\$64,725	\$86,300	\$86,301 or greater	
7	\$48,650	\$72,975	\$97,300	\$97,301 or greater	
8	\$54,150	\$81,225	\$108,300	\$108,301 or greater	

IMPORTANT: *For Family Units over 8, add \$5,500 per person.

Section 2: Guarantor/Insurance (Financially Responsible Individual) Information

Patient's Relation to Guarantor: Self (skip to Plan 1 Information) Child Parent Spouse Employer Other _____

First Name: _____ Middle Name: _____ Last Name: _____ Suffix: _____

Date of Birth: _____ SSN: _____ Sex: M F Marital Status: Single Married Widowed

Address: _____ City: _____ State: _____ Zip: _____

Plan 1 Information

Insurance Company: _____ Group Number: _____ Claim Member ID: _____

Plan 2 Information

Insurance Company: _____ Group Number: _____ Claim Member ID: _____

Section 3: Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____ City: _____ State: _____

Section 4: Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, SCHC will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our finance office. I hereby assign, transfer, and set over to SCHC all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of SCHC. I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

I agree to abide by SCHC treatment and payment authorization policy.

Notice of Privacy Practices

I have been given, read, and understand the Notice of Privacy Practices of SCHC.

I have refused my copy of the Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____

Date of birth: _____

Reason for Visit: _____

Allergies: _____

Medical Conditions: _____

Surgeries: _____

List All Medications and Dosages: _____

Family History: _____

Are you a smoker? Yes No **If yes, would you like assistance with quitting?** Yes No

Do you use either alcohol or drugs, including marijuana? Yes No **If yes, please list the type of substance used and how often it is used:** _____

We ask everyone about their reproductive health needs. Do you want to talk about contraception or pregnancy prevention during your visit today? Yes No

Alternative Contact Authorization

This authorization allows SCHC providers and staff to communicate information regarding your medical care to the individual(s) you designate. As part of SCHC's Patient Privacy Policy, SCHC will release your health information only as you specifically authorize. Please check whether you DO or DO NOT authorize SCHC to release your health information. Please complete the contact information portion only for individuals authorized to receive your health information.

I DO NOT authorize anyone to receive information regarding my medical care.

I DO AUTHORIZE providers and staff of SCHC to release information regarding my medical care.

Contact #1 Patient lives with this contact

Name: _____ Relationship: _____

Phone: _____ All Information Emergencies only Appointments Financial Account

Test Results Other: _____

Contact #2 Patient lives with this contact

Name: _____ Relationship: _____

Phone: _____ All Information Emergencies only Appointments Financial Account

Test Results Other: _____

Consent to Treat a Minor

The Minor Treatment Consent Form gives our providers permission to treat your child when he or she is in someone else's care. Please list the person's name, phone number, and his/her relationship to your child in the space provided.

I, _____, the legal parent/guardian of _____ (Minor's Name), grant permission to the following individual(s) to request and approve medical care for the above named minor:

Name: _____ Relationship to child: _____ Phone: _____

Parent/Legal Guardian Signature: _____ Date: _____

SCHC Witness Signature: _____ Date: _____

NAME:		DATE:
DATE OF BIRTH:		AGE:
PRIMARY CARE PHYSICIAN:		PHONE:
CURRENT THERAPIST/COUNSELOR		PHONE
WHO REFERRED YOU TO THIS PRACTICE		PHONE
Name:		
MOTHER'S NAME	AGE	FATHER'S NAME
		AGE
Address:		Address:
Phone:	Phone:	
Marital Status of Parents: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Blended <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Who legal custody?		Type:
Who has physical custody?		Type:
Please describe the presenting problem:		
What concerns you most about your child?		
When did you first notice this problem?		
How has this problem Affected his/her function?		
At home:		
At school/work:		
Community:		
<i>Continued on next page:</i>		

Do you have other concerns that you would like addressed?

Symptom Checklist

Please check the symptoms below that your child has been experiencing over the past few weeks which cause you to worry.

Yes	No	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	Depression: sad, irritable, hopeless, helpless, difficulty sleeping, crying, sleeping too much, decreased energy/fatigue, feelings of worthlessness or guilt, difficulty thinking or concentrating, difficulty making decisions, social withdrawal/isolative behaviors, lack of interest in things, suicidal thoughts, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings: energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety: worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Problem: fights/physical aggression, anger, arguing, truancy, destruction of property, fire setting, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Attention/Hyperactivity Problem: difficulty paying attention, easily distracted, difficulty completing tasks, hyperactive, impulsive, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Eating Behaviors: too much/significant weight gain, too little/significant weight loss, fear of weight gain, distorted body image, excessive exercising, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Social Anxiety: shy and/or afraid to be around others, avoidance of crowds, avoidance of public places, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Remembering Past Traumas: frequent nightmares, intrusive and/or recurrent memories, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Autism: social and language impairments, rigidity, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Psychosis: hearing voices, seeing things, paranoia, delusions, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Dissociation: feeling outside your body or things are not real, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever harmed themselves intentionally?
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever attempted suicide?
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever harmed others? (including harm to animals)

If yes, please explain:

Please list all CURRENT psychiatric medications.

Medication Name:	Dose(s)	Date(s)	Response(s) & Side-effects	Provider/Facility

Past Psychiatric History

Please list all PAST psychiatric medications.

Please answer the questions below.

Has your child ever been admitted to a psychiatric hospital (this includes residential or day treatment programs, including any alcohol and drug treatment programs)? *(If yes, please list below.)*

Yes **No**

Date: Month/Year Diagnosis: Length of Stay: Facility/Location:

Has your child ever received mental health or substance use disorder (alcohol/drug) treatment as an outpatient (counseling or medication)? *(If yes, please list below.)*

Date: Provider: Reason:

Date: Provider: Reason:

Date: Provider: Reason:

Family History

Has anyone in your family been diagnosed or treated for: (Please list family member, mother, father, etc)

Diagnoses	Yes	No	Family Member	Diagnoses	Yes	No	Family Member
Depression	<input type="checkbox"/>	<input type="checkbox"/>		Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		Completed Suicide	<input type="checkbox"/>	<input type="checkbox"/>	
ADHD	<input type="checkbox"/>	<input type="checkbox"/>		Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>		PTSD	<input type="checkbox"/>	<input type="checkbox"/>	
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>		OCD	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>		Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Autism	<input type="checkbox"/>	<input type="checkbox"/>		Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Asperger's	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
PDD	<input type="checkbox"/>	<input type="checkbox"/>		Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	

Child Psychiatric Intake Form

Are there any other family medical problems that run in your family?		<input type="checkbox"/>	<input type="checkbox"/>	
If yes, what disease and who did/does it effect? (Please list disease and family member.)				
Disease	Family Member	Disease	Family Member	
1.		5.		
2.		6.		
3.		7.		
4.		8.		
Has any family member been admitted to a psychiatric hospital? If yes,		<input type="checkbox"/>	<input type="checkbox"/>	<i>Please list below.</i>
Date: Month/Year	Diagnosis	Family Member	Facility/Location	
If known, what medications were used in treatment?				

Childs Medical History

Please list any drug allergies and describe the reaction that your child had:							
Drug Name	Reaction						
Has your child ever had:	Yes	No				Yes	No
Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems			<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer			<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	GERD (acid reflux)			<input type="checkbox"/>	<input type="checkbox"/>
Back or neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease			<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems			<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems			<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Cancer			<input type="checkbox"/>	<input type="checkbox"/>
If yes for cancers, what type and describe any required treatment?							

Child Psychiatric Intake Form

Any other medical problems not listed above? If so, please list here:

Please list ALL surgeries: **List Non-Psychiatric hospitalizations:**

1.	1.
2.	2.
3.	3.

List ALL **non – psychiatric** medications & doses that your child is *currently* taking, including supplements, vitamins and over the counter medications.

Name	Dosage	Duration	Response

Developmental History:

At what age did your child achieve the following milestones?

Age	Milestone
	Language (age at first using words, sentences, etc.)
	Fine Motor Skills (building towers with cubes, drawing circles, etc.)
	Gross Motor Skills (rolling over, standing, walking, etc.)
	Toilet Training

Has your child experienced any regression of these skills? If yes, explain:

Yes No

Does your adolescent have a job?

Is your child sexually active?

Are you concerned about your child's sexual activities?

Does your child have quality relationships with other children? *If no, please explain:*

Has your adolescent had a recent change in friendships? *If yes, what changes concern you?*

Do you have any concerns regarding your child's friendships? *If yes, please explain:*

Too Old Too Young Truant Gang Fringe

Drug Alcohol Violence Too Many

Too Few Sexual Promiscuity Too much time Other

If other, please list concern:

Substance Use

Please indicate any substances used currently or in the past by your child:

Substance	Yes	No	If yes, how long, frequency, last use and age?
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	
Vapes	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	
Cocaine/Crack	<input type="checkbox"/>	<input type="checkbox"/>	
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	
Huffing (gas, aerosol)	<input type="checkbox"/>	<input type="checkbox"/>	
Prescription Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Bath Salts	<input type="checkbox"/>	<input type="checkbox"/>	
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	

School

Where does your child attend school?			
In what grade level is he/she?			
What are his/her typical grades?			
What are your child's academic strengths?			
Academic weaknesses?			
Has there been a change in your child's performance at school? <i>If yes, please describe:</i>	<i>Describe</i>		Yes
			<input type="checkbox"/>
			<input type="checkbox"/>
Has your child received IQ or Academic Testing? <i>If yes, what were the results?</i>	<i>Results</i>		<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Child Psychiatric Intake Form

Receive any resource/assistance? (for which classes/how many hours?)						<input type="checkbox"/>	<input type="checkbox"/>
Class		Hours		Class		Hours	
Class		Hours		Class		Hours	
Class		Hours		Class		Hours	
Participate in accelerated or honors programs? <i>If yes, please explain below:</i>						<input type="checkbox"/>	<input type="checkbox"/>
Is on a 504 plan? <i>Please explain below:</i>						<input type="checkbox"/>	<input type="checkbox"/>
Is on an Individual Education Plan (IEP)? <i>Please explain below:</i>						<input type="checkbox"/>	<input type="checkbox"/>
Has your child had problems with any of the following? <i>If yes to any, please explain.</i>							
Problem		Yes	No	Problem		Yes	No
Truancy		<input type="checkbox"/>	<input type="checkbox"/>	Detention		<input type="checkbox"/>	<input type="checkbox"/>
Fights		<input type="checkbox"/>	<input type="checkbox"/>	Suspension		<input type="checkbox"/>	<input type="checkbox"/>
Absenteeism		<input type="checkbox"/>	<input type="checkbox"/>	School refusal		<input type="checkbox"/>	<input type="checkbox"/>
Explain:							

Social History

Is your child your biological child? <i>If not, please explain:</i>			Yes	No
Describe			<input type="checkbox"/>	<input type="checkbox"/>
If your child was adopted, at what age was he/she adopted?			Age	
Is there any contact with their biological parents?			<input type="checkbox"/>	<input type="checkbox"/>
Where was your child born and raised?				
Do you have a religious preference in the household? <i>If yes, what is that preference?</i>			Yes	No
Religious Preference			<input type="checkbox"/>	<input type="checkbox"/>
Has your child experienced any problems related to race, religion, or culture? <i>If yes, explain:</i>			Yes	No
Explain:			<input type="checkbox"/>	<input type="checkbox"/>

Please list all relevant family members related to the child (step-parents, siblings, step, grand, etc.):

Family Member	Relationship	Lives at home	Family Member	Relationship	Lives at home
		<input type="checkbox"/>			<input checked="" type="checkbox"/>
		<input type="checkbox"/>			<input type="checkbox"/>
		<input type="checkbox"/>			<input type="checkbox"/>
		<input type="checkbox"/>			<input type="checkbox"/>
		<input type="checkbox"/>			<input type="checkbox"/>
		<input type="checkbox"/>			<input type="checkbox"/>

Is there anything else we should know about you?

Abuse History

Has your child ever been the victim of abuse or neglect? <i>If yes, what was the nature of the abuse?</i>	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

Has your child ever been involved with the following and, if yes, please explain:

Service	Yes	No	If yes, please explain:
Child Protective Services	<input type="checkbox"/>	<input type="checkbox"/>	
Law Enforcement	<input type="checkbox"/>	<input type="checkbox"/>	
Detention Involvement	<input type="checkbox"/>	<input type="checkbox"/>	
Court Involvement	<input type="checkbox"/>	<input type="checkbox"/>	
Probation	<input type="checkbox"/>	<input type="checkbox"/>	
Juvenile Probation	<input type="checkbox"/>	<input type="checkbox"/>	
Detention	<input type="checkbox"/>	<input type="checkbox"/>	
Early Intervention Service (ages 0-3)	<input type="checkbox"/>	<input type="checkbox"/>	
Head Start:	<input type="checkbox"/>	<input type="checkbox"/>	

Emergency Contact _____ Relationship _____

Phone Number _____

By signing below, I certify all information is true and correct to the best of my knowledge and I consent to treatment for my minor child.

Signature _____

Date _____