FAMILY WELLNESS CENTER OF NORMAN

2760 Washington Drive, Suite 110 Norman, OK 73069
Phone (405)360-2827   Fax (405)283-1124
www.FamilyWellnessNorman.com

Welcome to Family Wellness Center of Norman. We strive to provide compassionate behavioral health care for children, adolescents, and their families. Please fill out the following forms prior to coming to your appointment. We ask that you bring the following forms completed along with the following items or arrive thirty minutes early to your first appointment in order to allow time to sign any consent forms needed upon your arrival.

Here are some things to bring to your first appointment:

- Insurance cards and subscriber information (primary subscriber's full legal name, date of birth and social security number)
- ID
- DHS or custody papers
- Medication list
- Previous provider's contact information for record requests

Some of our providers see patients at our office through telemedicine, a video conference. Telemedicine is highly acclaimed by providers and patients across the world, as the provider can provide the same amount of care through video conference as they would be able to if they were here in person. This also offers patients the benefit of doing a video visit from home in cases of convenience, emergency, or other issues that may make coming to our office difficult for the patient. We will not set up a telemedicine visit without your knowledge or consent. If you do not feel comfortable seeing a provider through telemedicine visits at our office or from your home, our providers also see patients in person at our office and we would be happy to schedule either appointment for you.

Family Wellness Associates Child/Adolescent Intake Form

CLIENT NAME: ____

PLEASE FILL OUT FORMS IN BLACK INK ONLY

Patient's first name: __________________________ MI: ____ Last name: _______________________________

Date of birth: ______ / ______ / _______ Social Security #: _______ - ______ - _________

Sex: M / F / Other: _________________________________ Race: _________________________________

Address: _____________________________________ City: _____________________ Zip Code: ___________

Mailing address (if different than above): ____

Referred by: ___________________________________ Interested in: Medication Management / Therapy / Both

Primary Provider: __________________________________ Therapist: __________________________________

Preferred pharmacy (name and address) : ____

Home phone number: ____________________________ Cell phone number: ____________________________

Is it okay for us to leave a detailed voice message? Yes / No

Guardian name: ____ Relationship: ________________________

Home phone number: ____________________________ Cell phone number: ____________________________

Guardianship or custody status: ____

Caseworker name and phone number: ____

Emergency contact ____ Relationship: ________________________

Home phone number: ____________________________ Cell phone number: ____________________________

Emergency contact ____ Relationship: ________________________

Home phone number: ____________________________ Cell phone number: ____________________________

Insurance subscriber's full name: ____ Relationship: _____________________

Subscriber's date of birth: ________ / ________ / _________ Social Security #: _________ - ________ - ___________

Primary insurance name: ____ Copay: ________________

Policy #: ___________________________________ Group #: ________________

Secondary insurance name: ____ Copay: ________________

Policy #: ___________________________________ Group #: ________________

If you would like to join our patient portal to have access to the patient's visit notes, lab results, requesting medication refills, appointment reminders, asking your provider a question, receiving health reminders, notifications from your provider, and much more, please print your email address below. **Sign up for Patient Portal?:** Yes / No

If yes, print email address: ____

Family Wellness Associates   Child/Adolescent Intake Form

CLIENT NAME: ____

Areas of Concern (Check all that apply)

Personal/Social Adjustment

[ ] Unduly sad
[ ] Overly anxious
[ ] Overly aggressive
[ ] Temper tantrums
[ ] Withdrawn or shy
[ ] Disturbing habits or mannerisms
[ ] Strange or bizarre behavior
[ ] Problems in peer relationships
[ ] Drug or alcohol problems
[ ] Problems with the law
[ ] Harms self or others (suicidal or homicidal)
[ ] Other: ___________________________

School Adjustment

[ ] Academic problems
[ ] Difficulty with peers
[ ] Difficulty with authority
[ ] Attendance problems or reluctance to go
[ ] Behavior problems
[ ] Learning disabilities
[ ] Attentional problems
[ ] Aches and pains related to school
[ ] Other: ___________________________

Family Adjustment

[ ] Parent-child problem
[ ] Marital conflict or co-parenting problems
[ ] Sibling conflict
[ ] Recent family changes
[ ] Neighborhood difficulties
[ ] Mother experiencing difficulties
[ ] Father experiencing difficulties
[ ] Sibling experiencing difficulties
[ ] Drug or alcohol problems in family
[ ] History of trauma or loss
[ ] Domestic violence
[ ] Abuse
[ ] Other: ___________________________

Physical/Developmental Factors

[ ] Eating
[ ] Sleeping
[ ] Toileting
[ ] Grooming
[ ] Language or speech
[ ] Perceptual/visual functions
[ ] Motor coordination problems
[ ] Other: __________________________

Family Wellness Associates   Child/Adolescent Intake Form

CLIENT NAME: ____

History of Current Problems

Duration and primary concern (include changes in mood, behavior, sleep, eating, free-time activities, and school concerns). Please use backside of page for additional information.

____

____

____

____

____

____

What have you already done to address this concern and how effective were these efforts?

____

____

____

____

Was there an event that caused you to seek treatment now?

____

____

____

____

School History

Current school: ____________________________________

Current grade level: _________________________________

Teacher's name: ___________________________________

Did your child have to repeat a grade?

____

Is your child requiring special services in school (either an IEP or a 504B plan)?

____

Is your child in the gifted program?

____

Is your child involved in any extra-curricular activities?

____

Does your child's teacher(s) have any concerns?

____

____

Please list all other evaluations your child has had (i.e. Psychological, Educational, Speech, Occupational Therapy)

____

____

____

____

Past Psychiatric History

Outpatient psychotherapy?

____

____

____

Family therapy? ____

____

____

Individual therapy? ____

____

____

CLIENT NAME: ____

Group therapy? ____

____

____

Inpatient (Hospital or Residential)?

____

____

____

Past suicidal ideation? [ ] Yes [ ] No If yes, number of attempts, how when, and how?

____

____

____

____

Current suicidal ideation? [ ] Yes [ ] No If yes, number of attempts, how when, and how?

____

____

____

____

Previous diagnosis:

____

____

____

____

<u>Medical History</u>

Any significant or relevant medical problems:

____

____

____

____

____

List all **current** prescription medications, over-the-counter medications, or supplements and how often you take them:

____

____

____

____

____

____

List all **past** prescription medications, over-the-counter medications, or supplements and how often you took them:

____

____

____

____

____

Allergies: ____

____

Vision Problems: ____

____

Hearing Problems: ____

____

CLIENT NAME: ____

Review of Systems

What symptoms are you experiencing?

- YES / NO Constitutional: Weight loss, weight gain, fever, poor appetite, fatigue, insomnia, night sweats
- YES / NO Eyes: Blurry vision, eye pain, discharge, redness, decrease in vision, dry eyes, double vision
- YES / NO ENT: Sore throat, hoarseness, ear pain, hearing loss, nose bleeds, tinnitus, sinus problems
- YES / NO Cardiovascular: Chest pain, palpitations, rapid heart rate, swelling in legs or feet, fainting
- YES / NO Respiratory: Shortness of breath, cough, coughing blood, tuberculosis, excess sputum production
- YES / NO Gastro: Nausea, vomiting, diarrhea, constipation, blood in stool, heartburn, trouble swallowing
- YES / NO Genitourinary: Frequent urination, blood in urine, loss of bladder control, painful urination, urinary retention, frequent UTI's
- YES / NO Musculoskeletal: Joint pain, muscle pain, frequent leg cramps, weakness, bone pain, joint swelling, back pain
- YES / NO Skin: Rash, hives, hair loss, skin sores or ulcers, itching, skin thickening, nail changes, mole changes
- YES / NO Endocrine: Goiter, heat intolerance, cold intolerance, increased thirst, excess sweating
- YES / NO Neurological: Seizures, tremors, migraines, numbness, dizziness, loss of balance, slurred speech, stroke
- YES / NO Hem/Lymphatic: Low blood count, easy bruising, swollen lymph nodes, transfusions, prolonged bleeding, blood clots
- YES / NO Allergy/Immune: Allergic reactions, hay fever, frequent infections, hepatitis, HIV positive, positive TB
- YES / NO Psychiatric: Anxiety, depression, panic attacks, use of anti-depressants
- YES / NO Other Complaints: ____

Substance Use and Habits

Alcohol? [ ] Yes [ ] No If yes, how often?

____

Recreational Drugs? [ ] Yes [ ] No If yes, how often and what kinds?

____

____

Smoker? [ ] Yes [ ] No If yes, how often? Interested in quitting?

____

____

How often does your child sleep and for how long?

____

How are your child's eating habits?

____

Is your child dating? [ ] Yes [ ] No

Is your child sexually active? [ ] Yes [ ] No [ ] Unknown

If female, has your child reached mensus (menstral cycle)? [ ] Yes [ ] No [ ] Unknown

List any other significant habits/interests:

____

____

Trauma History

Has your child ever experienced or witnessed any kind of abuse? [ ] Yes [ ] No If yes, what kind?

Emotional abuse:

____

Physical abuse:

____

Sexual abuse:

____

CLIENT NAME: ____

Family History

Please list below family member(s) who have (or had) emotional problems, depression, anxiety, psychiatric illness, drug or alcohol abuse, attentional difficulties, learning disabilities, autism, developmental delays or retardation, abuse, neglect, suicide attempts, etc.

____
____
____
____

Prenatal/Postnatal Developmental Factors

Prenatal History

Mothers health during pregnancy was:
____

Age of mother at child's birth?
____

Did the mother have any exposure to drugs, alcohol, caffeine or tobacco during the pregnancy? If yes, what?
____
____

Child born on schedule? [ ] Yes [ ] No If early, how premature?
____

Duration of labor? ____

Was delivery? [ ] Normal [ ] Breech [ ] Caesarian [ ] Forceps [ ] Suction [ ] Induced

Child's birth weight? _____________ Length? _____________ APGAR Score _____________

Were there complications following birth? [ ] Yes [ ] No If yes, what were they?
____
____

Postnatal Period / Infancy / Toddler

Feeding problems? [ ] Yes [ ] No

Sleep problems? [ ] Yes [ ] No

Problems with responsiveness (alertness)? [ ] Yes [ ] No

Were there health or congenital problems during infancy? [ ] Yes [ ] No

How was it to care for this child?

[ ] Very easy [ ] Easy [ ] Average [ ] Difficult [ ] Very Difficult

How did the child behave with other people?

[ ] More Sociable than Average [ ] Average Sociability [ ] More Unsociable than Average

Rate the activity level of the child:

[ ] Very Active [ ] Active [ ] Average [ ] Less Active [ ] Not Active

Developmental Milestones

Age child sat up: [ ] 3-6 months [ ] 7-12 months [ ] Over 12 months

Age child crawled: [ ] 6-12 months [ ] 13-18 months [ ] Over 18 months

Age child walked alone: [ ] Under 1 year [ ] 1-2 years [ ] 2-3 years

Age child spoke single words other that 'mama' or 'dada'?

[ ] 9-13 months [ ] 14-18 months [ ] 19-24 months [ ] 25-36 months [ ] 37-48 months

Age child strung two or more words together:

[ ] 9-13 months [ ] 14-18 months [ ] 19-24 months [ ] 25-36 months [ ] 37-48 months

Age toilet trained?

Bladder controlled: [ ] Under 1 year [ ] 1-2 years [ ] 2-3 years [ ] 3-4 years

Bowel controlled: [ ] Under 1 year [ ] 1-2 years [ ] 2-3 years [ ] 3-4 years

How long did toilet training take from onset to completion?

[ ] Less than 1 month [ ] 1-2 month [ ] 2-3 months [ ] More than 3 months [ ] More than 1 year

CLIENT NAME: ____

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to address and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future mental health or condition and related health care services.

USES AND DISCLOSURES OF HEALTH INFORMATION

Your protected health information may be used by our physician or other providers of services, our office staff and others outside of our office that is involved in your care and treatment or providing health care services to you, to pay your health care bills, to support the operations of the physician's practice and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health are and any related service.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services.

HEALTH CARE OPERATION: We may use and disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to quality assessment activities, employee review activities and conducting or arranging for other business activities. We may call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues such as Communicable Disease, Health Oversight: abuse or neglect, Food and Drug Administration requirements: Legal Proceedings, Law Enforcement: Coroners, Funeral Directors and Organ Donation Research; Criminal Activity, Military Activity and National Security; Worker's Compensation; Inmates, Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures are made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your physician, provider of service or the office staff has taken an action in reliance on the use or disclosure indicated in the authorization.

PATIENT’S RIGHTS: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request and receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon written request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to have your physician or provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to amend the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 14, 2003. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practice with respect to your protected health information.

Signature below only acknowledges that you have received this Notice of Privacy Practices

Print Patient or Guardian’s Name: ____

Patient or Authorized Guardian’s Signature: ____

Relationship to Patient: ____________________________________ Date Signed: __________________

CLIENT NAME: ____

PAYMENT POLICY, VERIFICATION OF APPOINTMENT PROCESS, AND CANCELLATION AGREEMENTS

I authorize Family Wellness to release any information acquired during my treatment to my insurance company and assign the insurance payments due to Family Wellness Center of Norman or Mobile Medical Solutions.
I understand that Family Wellness files my insurance as a courtesy, but the bill is my responsibility.
I understand that my insurance may not cover my entire visit and that co-payment may be required upon checking in or checking out at each appointment.
I understand that notice of cancellation must be given 24 hours in advance so that I will not be charged a fee of $50. I understand that by not providing the office with verification of my appointment 24 hours prior to my appointment that the office may schedule someone else in my appointment slot instead.
I understand that if I have consecutive missed appointments (two or more missed appointments in a row) that I may not receive my medication refills and I may further be dismissed as a patient.
I understand that I may be charged $1 for providers filling out paperwork (FMLA, Disability, Driver's License, etc.) or may be required to make an appointment to have such paperwork filled out by the provider.
I understand that if I have an outstanding balance of over $150, I need to pay the outstanding balance prior to being seen or my appointment will be cancelled until a payment or payment plan is made.
I understand that after sending multiple statements regarding an unpaid balance, I will not be able to be seen or get medication refills as all service will be terminated, and the balance will be sent to collections.

RELEASE OF INFORMATION TO DESIGNEE

I authorize Family Wellness to release any information acquired in the course of my treatment to the following designated person. I authorize the following designated person to access or change any information regarding my treatment. A designated person would be someone who is not myself or my legal parent/guardian. This release will automatically expire if guardianship has changed and any information given will be by provider's discretion if appropriate or client is in potential danger. **Please list restrictions, if any:**

____ ***I do not authorize release of any information to any designee***
____ **I do authorize release of information to a designee except the following:**

____ Appointments ____ Medications
____ Lab, X-rays, ECG ____ Progress Notes
____ Financial Statement, Billing, Receipts, or Payments
____ Other: ____

Name of designee: ____ Relation: ________________________________
Phone number: ______________________________________ Date Release Expires, if any: ________________________

CONSENT FOR USE OF TELEMEDICINE AND REMOTE INTERVIEW LISTENING

I understand that Telemedicine (video communication) is an optional feature that I can choose to use or not to use at the provider and I's discretion to communicate with the provider for my appointments. I understand that if the provider thinks my case is too severe that they may require me to be seen in person rather than by video. I understand that if I consent, an employee of Family Wellness may be listening to my psychiatric evaluation or medication check visit, for the sole purpose of transcribing the visit into my medical record. I understand that no other persons will be listening, and no recording will be made of the interview. I understand that all Family Wellness employees have signed confidentiality agreements and are required to keep all client information private. I understand that I have the right to refuse remote listening and transcribing, and I will still be able to receive medication management in person.

I hereby acknowledge that I have read or have been given these authorizations and fully understand the nature of the agreements.

Patient or Guardian's Signature: ____________________________________ Date Signed: _________________

CLIENT NAME: ____

Authorization for Release of Information

Client Name: ____

Date of birth: ________ / ________ / _________ Social Security #: __________ - _________ - ___________

Name of Company to Receive and Disclose PHI	**Name of Individual/Company/Facility to Receive and Disclose PHI**
Family Wellness Center of Norman	**Business** ___________________________________
and Mobile Medical Solutions	**Attn** ___________________________________
2760 Washington Drive Suite 110	**Address** ___________________________________
Norman, OK 73069	**City/State/Zip** _____________________________
Phone: 405-360-2827	**Phone #** ___________________________________
Fax: 405-283-1124	**Fax #** ___________________________________

Purpose of Release: ______Treatment_______

Information to be released /obtained for dates of treatment: _______________ to _____PRESENT____

__X__ Lab, X-rays, ECG __X__ Progress Notes _____ History and Physical

_____ Medication Record __X__ Discharge Summary _____ Other ___________________

I am requesting information be

__X__ Faxed to the above requestor _____ Mailed to the above requestor _____ Other: ______________

This consent for release of information may be revoked in writing at any time. Any release of information made between the time authorized and the time revoked shall not constitute a breach of confidentiality. Unless otherwise indicated, this release expires one year from date of signature. Date this release expires: _________________

I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by the authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law. Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Reproduction of this authorization is as authentic as the original signed authorization.

I understand the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

Client signature: ____ Date _________________

Parent/Legal Representative: ____ Date _________________

Description of Legal Representative's Authority: ____

Witness signature: ____ Date _________________

CLIENT NAME: ____

Informed Consent for Treatment with Psychoactive Medications

If you have any questions, you may request reviewing the following with the provider before starting medication.

By reading the following conditions and signing my name at the bottom of this document, I acknowledge that I understand all the following about the risks that are associated with psychoactive medications.

- The nature and seriousness of my mental condition for which the medication is recommended, and the reason for using the medication.
- Psychoactive medications have the potential for side effects. These side effects may involve the heart, nervous system, muscles, glands, urinary tract, bowels, blood, eyes, skin, and allergic responses. (This list is not all inclusive.) Most side effects are minor and reversible. However, some side effects are serious and may not be reversible such as tardive dyskinesia, which is a movement disorder. I also understand that sudden death has been reported in association with stimulants in children with structural cardiac abnormalities.
- Monitoring serum concentrations of some medications (e.g., lithium, valproic acid, etc.) may be necessary. Also for patients receiving second-generation antipsychotics, baseline and follow–up monitoring of serum lipid and glucose concentrations is recommended.
- Some medications have dependence and/or abuse potential (e.g., stimulants, sedatives, anxiolytics) and may produce serious withdrawal symptoms upon abrupt discontinuation.
- Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder and other psychiatric disorders. (See Medication Guide About Using Antidepressants in Children and Teenagers.)
- The improvement associated with psychoactive medications may be permanent or temporary. The medication will not cure the illness, but is recommended to help control the symptoms. Without medication the present mental condition may improve spontaneously, continue with little or no change, or worsen.
- The medication recommended and/or dosage used may not be approved by the Food and Drug Administration for the assigned psychiatric diagnosis or for all the age groups. However, data does exist to support the use for which medication is recommended.
- Alternatives to treatment with medications are no treatment, psychotherapy, and/or electro-conclusive therapy (the last is not available at this facility.) I understand the prognosis with and without the recommended medication treatment.
- I have the right to accept or refuse this medication treatment and the right to revoke consent at any time prior to or during treatment. This consent is being granted without threat or coercion expressed or implied. No guarantees or assurances have been made concerning the results of treatment with this medication.
- I have been informed that if I have any questions or concerns about my mental health condition and/or medication I may I may discuss them with my psychiatrist or nurse practitioner at our next visit.
- I understand that the patient is to take the prescribed medication only as prescribed and only for the condition for which it is prescribed.
- I understand that it is the responsibility of the patient or guardian of the patient to contact the provider prescribing the psychoactive medication for questions or concerns regarding the effect, or side effects of the prescribed drug or, in the event of medical emergency, emergency personnel.

I have read, or the provider has read and explained to me, and I do understand the foregoing risks that are associated with psychoactive medications. I have had the opportunity to have my questions answered. I understand the nature, purpose, and expected benefit of the recommended medication, the diagnosis and prognosis of the condition for which the medication is recommended, the alternatives to medication treatment including no treatment, and the significant risks and common side effects of the recommended medication. I do hereby give informed consent to the agreed upon treatment for the medications prescribed by the provider. *I understand that this release expires a year from the signed date.*

Signature of Client or Parent/Guardian: ____

Relationship to Client: ____________________________________ Date signed: _____ /_____ /_________