Agape Youth Behavioral Health Patient Information Form

Patient Information

Child's Name	Date of Birth	Age
School	Grade	
Referring Provider		
Primary Care Doctor	Therapist (if any)	

Mental Health Concerns and History

1. Please list your child's main symptoms/behaviors of concern:

2. What is your primary goal for this appointment?

3. Check below all services that you are interested in for your child:

☐Clarification of Diagnosis ☐Medication Treatment ☐Information About Psychotherapy/Behavioral Training

4. What mental health diagnoses has your child previously been given or do you suspect?

5. List all clinics or mental health centers that your child has been treated at previously:

Clinic or Center	Estimated Dates of Visits

6. Has your child ever had inpatient or residential treatment for mental health symptoms? ☐ Yes ☐ No

Facility	Reason for Hospitalization	Dates of Stay

7. List all current medications/supplements and doses below:

Medication	Dose (how much & how often)

8. List all past medications/supplements used for emotional or behavioral problems below (use blank paper if needed):

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped

Allergies, Medications, and Medical Concerns

1. Please list any known medication allergies or sensitivities: ☐ None
2. Please list any other known allergies (foods, seasonal): ☐ None
3. Please list any medical illnesses that your child has: ☐ None
4. Has your child ever had surgery or been hospitalized for medical reasons? ☐ Yes ☐ No

Facility	Reason for Surgery or Hospitalization	Dates

Birth and Developmental History

1. Age of biological mother at child's birth	2. Child's birth weight
3. Was biological mother exposed to toxins in pregnancy (i.e. medications, tobacco, street drugs, alcohol)? ☐ Yes ☐ No	
If yes, list toxins:	
4. Any complications during this pregnancy? ☐ Yes ☐ No List:	
5. Full-term ☐ Yes ☐ No	6. Home within 3 days of birth? ☐ Yes ☐ No
7. Please write the age at which your child was able to do the following things (if remembered)	
First walked?	Was toilet trained?
Said first words?	Used 2-3 word phrases with meaning?
8. Has your child ever had **psychological or IQ testing**? If so, please provide copies.	Yes No

Educational and Social History

1. Has your child ever received any special education services at school? ☐ Yes ☐ No		
2. Does your child have an IEP (Individualized Education Plan)? ☐ Yes ☐ No		
3. Has your child ever repeated a grade level? ☐ Yes ☐ No		
4. Has your child ever received any of the following services listed below:		
Physical Therapy ☐ Yes ☐ No Speech Therapy ☐ Yes ☐ No Occupational Therapy ☐ Yes ☐ No		
5. Has your child had significant disciplinary actions (i.e. suspensions, expulsions) at school? ☐ Yes ☐ No		
6. Had your child had legal problems (i.e. court appearance, probation)? ☐ Yes ☐ No		
7. Is your child interested in making and keeping friends? ☐ Yes ☐ No		
8. Potential stress history for child (check all that apply):		☐ Arrest/convictions of family members
☐ Parental divorce	☐ Parent separation or marital problems	☐ Exposure to a Natural Disaster
☐ Domestic violence	☐ Serious illness in family	☐ Death in family
☐ Victim of Physical Abuse	☐ Victim of Sexual Abuse	☐ Victim of Verbal/Emotional Abuse

9. List all immediate (biological) family members. Also list others living in the home:

Relation	Name	Age	Living in Home?	Children: current grade in school Adults: highest level of education
Bio Father				
Bio Mother				

Family History

1. Please list below any <u>biological</u> family members of the child who have had <u>any</u> of the following:
   - i. Sudden death, heart rhythm problems, genetic disorders
   - ii. Autoimmune disorders (i.e. thyroid disease, lupus, multiple sclerosis)
   - iii. Psychiatric conditions (i.e. anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD)
   - iv. Developmental conditions (i.e. mental retardation, learning problems, autistic disorders)
   - v. Neurological conditions (i.e. seizures, tics)
   - vi. Drug/alcohol problems

Relationship to Child (father, mother, brother, sister, grandmother, cousin, uncle, etc.)	Name or Description of Conditions *Please include any conditions from all of the categories listed above*

Agape Youth Behavioral Health Patient Information

Office Use Only: Provider _____

****IF FORM IS NOT FILLED OUT COMPLETELY AND CORRECTLY, INSURANCE MAY NOT PAY****

If incomplete or incorrect information is provided, Parent/Guardian is responsible for payment.

Patient Last Name: _____ **First Name:** _____ **MI:** _____

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

Birthdate: _____ Gender: _____ Race/Ethnicity: _____

SSN: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Parent or Guardian Information (Where billing statements will be sent):

Last Name: _____ First Name: _____ MI: _____

Preferred Email Address (for patient portal access): _____

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

Preferred Phone: _____ Alternate Phone: _____

Relationship: _____ SSN: _____ Employer: _____

Primary Insurance Coverage: _____

Policy Holder Last Name: _____ First Name: _____ MI: _____

Birth Date of Policy Holder: _____

Info: ☐ Same as Parent/Guardian Above (if not, please complete)

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

Preferred Phone: _____ Alternate Phone: _____

Relationship: _____ SSN: _____ Employer: _____

Secondary Insurance Coverage: _____

Policy Holder Last Name: _____ First Name: _____ MI: _____

Birth Date of Policy Holder: _____

Info: ☐ Same as Parent/Guardian Above (if not, please complete)

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

Preferred Phone: _____ Alternate Phone: _____

Relationship: _____ SSN: _____ Employer: _____

Signature of Parent/Guardian: _____ **Date:** _____

7446 Shallowford Road Suite 112/116
Chattanooga, TN 37421
423-443-3336 Ph
423-464-7510/423-641-8960 Fax

Agape Youth Behavioral Health
Patient Consent Form

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed mediation
- Performance of diagnostic procedures/tests

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **The consent will remain in full force until revoked in writing.**

I understand that Agape Youth Behavioral Health includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Agape Youth Behavioral Health will use any disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes, but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilizations of cultures and of other medically accepted laboratory tests, all of which the judgement of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes, but is not limited to: the authorization of payment directly to Agape Youth Behavioral Health of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee. I understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks. I hereby consent for billing and collection services to contract me by phone as necessary.

Healthcare operations include, but are not limited to: release of my medical information to any of my physicians and their offices, or insurance companies participating in my care or treatment and the quality of care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, physiological conditions, psychiatric conditions, and/or infection diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

(OPTIONAL) Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Agape Youth Behavioral Health. I acknowledge that I have been given the Agape youth Behavioral Health Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Parent/Guardian Signature: _____

Date: _____

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Authorization & Informed Consent

If you are not the legal guardian, a signed consent form is required from the custodial parent. If you are divorced, a copy of the divorce papers stating your legal guardianship is required prior to treatment.

I agree and consent to participate in the behavioral health care services offered and provided by Agape Youth Behavioral Health. I understand that I am consenting and agreeing only to those services that my provider qualified to provide within the scope of the provider's license, certification, and training.

I authorize Agape Youth Behavioral Health to release to my insurance company, managed care organization, state agency (ies), Health Care Financing Administration, third party administrators, and/or Worker's Compensation or its agents any information needed to process my claim and/or determine benefits payable to related services. I also authorize Agape Youth Behavioral Health to utilize a fax machine to transmit and/or all of the above medical records pertaining to my medical care of insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of medical records.

I grant permission for Agape Youth Behavioral Health to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to the purposes of treatment, payment, and healthcare operations.

I request that payment of Medicare, Medigap, Traveler's Railroad Retirement, Managed Care Organizations, Third Party Administrators, Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to Agape Youth Behavioral Health for services furnished to me or on my behalf by that provider.

Patient Signature: _____Date: _____

Guardian Signature: _____ Date: _____

Notice of Privacy Practices

I have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

** A copy is available for your records at your request.

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Authorization & Informed Consent

Fee Agreement & Waiver

Please Initial:

_____It is your obligation to stay current with your bill. Payment is due at the time services are provided. Future appointments will not be scheduled until your account is current. Please discuss any problems you may have with making payments as well as any changes in your financial situation.

_____ It is your responsibility to notify your provider 24 hours in advance if you are unable to keep your scheduled appointment. If you do not notify your provider, you may be billed for that session. Insurance carriers will not cover missed appointments, therefore, that portion of the bill would be your responsibility.

_____If insurance coverage is available, we will file for insurance reimbursement. This service is a courtesy we extend to our patients, not a requirement. Please provide the necessary information. Failure to do so will require full payment from guarantor on the account. You are also responsible for any deductibles or co-payments at the time of service.

_____ I understand that I am financially responsible for the deductible amount, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Agape Youth Behavioral Health and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned over to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs. I acknowledge the receipt of Agape Youth Behavioral Health Notice of Privacy Practices. I understand that questions or complaints should be directed to the privacy office.

_____ I understand that it is my responsibility to obtain a referral from my primary care physician, if required, and contact my insurance prior to my visit to receive information about the pre-authorization. Insurance companies will not backdate an authorization; therefor, if this step is omitted or forgotten, you are held liable.

_____ If my insurance plan has changed, it is my responsibility to notify the office prior to my appointment. In instances where my plan required pre-authorization or a referral from my primary care physician, it is my responsibility to notify the physician's office. If I do not give proper notification prior to the visit, and insurance denies a claim, I understand the bill is my obligation. This applies to all insurances.

_____We cannot resubmit claims for dates incurred before notification of an insurance change due to guidelines for timely filing.

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Agape Youth Behavioral Health

Patient Rights & Responsibilities

YOU HAVE THE RIGHT:

- To be treated with consideration, respect, and full recognition of your dignity and individuality regardless of your state of mind or condition.
- To be provided with treatment without regard to race, color, birthplace, language, gender, age, religion, or disability.
- To complete privacy of your medical and financial information.
- To be informed of treatment options and/or alternative treatment methods regardless of cost or benefit coverage.
- To be informed of the risks, benefits, and consequences of treatment or non-treatment.
- To be informed of the side effects of your medication or proposed medication.
- To participate in the development of your individual treatment plan.
- To participate in all decision-making regarding your behavioral health care, including discharge or aftercare planning.
- To be provided in quality treatment by competent staff members.
- To refuse to participate partially or fully in treatment or therapeutic activities (unless participation is ordered by the court).
- To be provided treatment in the least restrictive setting that is clinically appropriate, feasible and available.
- TO be provided with a copy of your basic rights and responsibilities and to have all questions answered to your satisfaction.
- To voice complaints about your services. You can continue to receive services without fear or receiving inadequate treatment.
- To be given information about the Declaration of Mental Health Treatment, or to designate a person to make decisions using a durable power of attorney for healthcare.
- To make recommendations about your rights and responsibilities.
- To be provided with a list of available advocacy services and contact information when requested.
- To ask for and receive information about your medical records, review the records, make corrections to your medical records, and to receive copies of your medical records.
- To be provided with an interpreter or any translation services free of charge to any member who needs such services, including but not limited to, members with limited English proficiency and members who are hearing impaired.

YOU ARE RESPONSIBLE:

- To provide accurate information to your provider
- To treat health care providers/ staff with respect and dignity.
- To cancel appointments you are unable to keep.
- To follow the instructions and guidelines given by providers.
- To participate, to the degree possible, in understand your behavioral health problems and to develop mutually agreed upon treatment goals.

I have read the Rights and Responsibilities and all my questions have been answered to my satisfaction.

Parent/Guardian Signature:_____
Date:_____
Patient Signature (If over 18):_____
Date:_____

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PATIENT EMAIL AND TEXT MESSAGING REGISTRATION FORM

Agape Youth Behavioral Health now has the ability to provide our patients with certain types of information via email and/or text messaging. Appointment confirmations can be sent by both email and text. We also can give access to our patient portal through your email. If you wish to have the opportunity to receive this information, please complete the form below.

Agape Youth Behavioral Health believes strongly in protecting the privacy of our patients. When you provide this information, it is only used as a way to communicate with you. Patient names will be listed in appointment reminders.

Please print all information neatly and legibly.

Patient Name_____

Email Address_____

Choose One:

- ○ Yes, please sign me up to receive email appointment confirmations
- ○ No, I do not wish to receive email appointment confirmations

Choose One:

- ○ Yes, please give me access to the patient portal through my email (You will receive an email to allow sign up)
- ○ No, I do not want patient portal access

SS# _____We must have patient's social to access patient portal

Cell Phone Number_____

Choose One

- ○ Yes, please sign me up to receive text messaging appointment confirmations
- ○ No, I do not wish to receive text messaging appointment confirmations

I hereby give Agape Youth Behavioral Health permission to send messages to me via email and/or text messaging as means of communication as indicated by my selection above.

Signature_____

Printed Name of Parent/Guardian_____

Date_____

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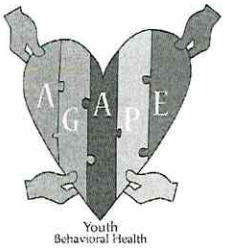

Agape Youth Behavioral Health
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423.443.3336

Authorization to Release Healthcare Information

Patient's Name:_____ Date of Birth:_____

I request and authorize _____Agape Youth Behavioral Health and Providers_____

To _____ **release** and/or _____ **obtain** health care information of the patient names above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

☐ Coordination of Care
☐ Continuity of Care
☐ Legal Purposes
☐ Other: _____

All information available may be released including psychological testing, lab testing, and any other reports, except as listed: _____
_____

Signature: _____ Date: _____
Printed Name: _____
Relationship to Patient: ☐ Self ☐Parent/Legal Guardian

THIS AUTHORIZATION IS VALID FOR ONE YEAR UNLESS REVOKED BEFORE THAT TIME.
FORM MUST BE FILLED OUT COMPLETELY.