

# *Heritage Behavioral Health Consultants*

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Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

## **OFFICE HOURS**

Regular support staff hours are from 8:00am to 5:00pm Monday through Friday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

## **SESSIONS**

Full sessions are 45 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee. Group sessions are typically one hour and 15 minutes long.

## **CANCELLATIONS**

There is no charge for missed appointments IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE. If the appointment is for Monday, the cancellation may be made-by leaving a message with the answering service. WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.

## **EMERGENCY SERVICES**

Emergency consultation is provided 24 hours each day, seven days a week. Your clinician usually will be available to assist you personally: however, at times, a colleague may cover calls. You may reach us at (713)365-9015. If we do not answer the page in 30 minutes, please page a second time and let the service know this is an emergency. If the consultation requires more than 15 minutes, you may be billed for time.

## **NOTICE OF PRIVACY PROCEDURES**

In accordance with the Health Insurance Portability and Accountability Act (HIPPA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2) provide you with a Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3) abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5) accommodate reasonable requests you may have to communicate health information by alternative means or at

alternative locations. Please refer to our Notice of Privacy Practices for detailed information.

**FEES**

Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office; however for those clients that belong to an insurance company that wish to file, we will give you an itemized statement so that you can file it with your insurance company in order to have them reimburse you directly.

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

**TYPES OF THERAPY AND ASSESMENTS**

A variety of therapies are available depending on your needs and wishes. During your first visit, you and one of our clinicians will evaluate together what issues you wish to address and the type of therapy that would be most appropriate for you.

Please check each type of therapy or assessment you feel may be appropriate.

- Marriage or Relationships Counseling
- Individual Counseling
- Parent Consultation
- Family Therapy
- Attention Deficit Disorder Assessment
- Psychological Testing

**PERSONAL RELATIONSHIPS**

Our goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that we may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT AND AGREE TO ITS TERMS.

Patient Name (please print) : \_\_\_\_\_

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

I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES OF HBHC AND AGREE TO ITS TERMS.

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

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Heritage Behavioral Health Consultants

## CHILD PATIENT INFORMATION

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

Patient's Name: \_\_\_\_\_ Referred By: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female

Patient's Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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

If Appropriate:

Which parent has legal custody: \_\_\_\_\_

Stepfather's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Stepmother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Where may we leave voice mail messages for you?:  Cell  Home  Office

Would you like an invoice after every visit? Yes  No

Would you like to keep your credit card info on file for ease of payment: Yes No

Card Holder Name: \_\_\_\_\_

Credit Card No.: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

CVV Code: \_\_\_\_\_ (3 digit code on back of card)

Signature: \_\_\_\_\_

## Heritage Behavioral Health Consultants Child Checklist of Characteristics

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Person completing this form: \_\_\_\_\_

Many concerns can apply to both children and adults. If you have brought a child for evaluation or treatment first please mark all of the items that apply to your child on this list. Feel free to add any others at the end under "Any other characteristics"

- |  |   |
|--|---|
| <input type="checkbox"/> Affectionate  | <input type="checkbox"/> Lacks respect for authority, insults, provokes, manipulates  |
| <input type="checkbox"/> Argues/talks back, smart-alecky, defiant  | <input type="checkbox"/> Learning Disability  |
| <input type="checkbox"/> Bullies/intimidates, teases, inflicts pain on others, is bossy to others, pick on, provokes | <input type="checkbox"/> Legal disability—truncy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales   |
| <input type="checkbox"/> Cheats  | <input type="checkbox"/> Lying  |
| <input type="checkbox"/> Cruel to animals  | <input type="checkbox"/> Low frustration tolerance, irritability  |
| <input type="checkbox"/> Concern for others  | <input type="checkbox"/> Mental retardation   |
| <input type="checkbox"/> Conflicts with parents over persistent rule breaking, money, chores, homework,              | <input type="checkbox"/> Moody  |
| <input type="checkbox"/> Grades  | <input type="checkbox"/> Nail biting  |
| <input type="checkbox"/> Choices in music/clothes/or friends.  | <input type="checkbox"/> Nervous  |
| <input type="checkbox"/> Complains   | <input type="checkbox"/> Nightmares   |
| <input type="checkbox"/> Cries easily, feelings are easily hurt  | <input type="checkbox"/> Need for high degree of supervision at home over play chores/schedule                                  |
| <input type="checkbox"/> Dawdles, procrastinates, wastes time  | <input type="checkbox"/> Obedient   |
| <input type="checkbox"/> Difficulties with parents paramour/new marriage/new family                                  | <input type="checkbox"/> Obesity  |
| <input type="checkbox"/> Dependent, immature   | <input type="checkbox"/> Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, fidgety, noisiness |
| <input type="checkbox"/> Development delays  | <input type="checkbox"/> Oppositional, resists, refuses, does not comply, negativism  |
| <input type="checkbox"/> Disrupts family activities  | <input type="checkbox"/> Prejudiced, bigoted, insulting, name calling, intolerant   |
| <input type="checkbox"/> Disobedient, uncooperative, refuses, noncompliance, doesn't follow rules                    | <input type="checkbox"/> Pouts  |
| <input type="checkbox"/> Distractible, inattentive, poor concentration, daydreams, slow to respond                   | <input type="checkbox"/> Recent move, new school, loss of friends   |
| <input type="checkbox"/> Dropping out of school  | <input type="checkbox"/> Relationships with brothers/sisters or friend/peers and poor—competition, fights, teasing/provoking    |
| <input type="checkbox"/> Drug or alcohol use   | <input type="checkbox"/> Responsible  |
| <input type="checkbox"/> Eating-poor manner, refuses, appetite increase/decrease, odd combinations, overeats         | <input type="checkbox"/> Rocking or other repetitive movements  |
| <input type="checkbox"/> Exercise problems   | <input type="checkbox"/> Runs away  |
| <input type="checkbox"/> Extracurricular activities interfere with activities  | <input type="checkbox"/> Sad, unhappy   |
| <input type="checkbox"/> Failure in school   | <input type="checkbox"/> Self-harming behaviors, biting or hitting self, head banging, scratching self                          |
| <input type="checkbox"/> Fearful   | <input type="checkbox"/> Speech difficulties  |
| <input type="checkbox"/> Fighting, hitting, violent, aggressive, hostile, threatens, destructive                     | <input type="checkbox"/> Sexual—sexual preoccupation, public masturbation, inappropriate sexual behaviors                       |
| <input type="checkbox"/> Fire setting  | <input type="checkbox"/> Shy, timid   |
| <input type="checkbox"/> Friendly, outgoing, social  | <input type="checkbox"/> Stubborn   |
| <input type="checkbox"/> Hypochondriac, always complains of feelings sick  | <input type="checkbox"/> Suicide talk or attempts   |
| <input type="checkbox"/> Immature, clowns around, has only younger playmates   | <input type="checkbox"/> Swearing, blasphemes, bathroom language, foul language   |
| <input type="checkbox"/> Imaginary playmates, fantasy,   | <input type="checkbox"/> Temper tantrums, rages   |
| <input type="checkbox"/> Independent   | <input type="checkbox"/> Thumb sucking, finger sucking, hair chewing  |
| <input type="checkbox"/> Interrupts, talks out, yells  | <input type="checkbox"/> Tics-involuntary rapid movements, noises, or word productions  |
| <input type="checkbox"/> Lacks organization, unprepared  | <input type="checkbox"/> Teased, picked on, victimized, bullied   |
|  | <input type="checkbox"/> Truant, school avoiding  |
|  | <input type="checkbox"/> Underachieve, slow-moving, or slow-responding, lethargic   |
|  | <input type="checkbox"/> Uncoordinated, accident—prone  |
|  | <input type="checkbox"/> Wetting or soiling in the bed or clothes   |
|  | <input type="checkbox"/> Work problems, employment, work holism, overworking, can't keep a job                                  |

Any other characteristics: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it? \_\_\_\_\_  
\_\_\_\_\_

Chief Concern: Please describe the main reason you are here today: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treatment History:

Has your child ever received psychological, psychiatric or counseling services before?

Yes       No

When	From whom	For what problem	With what results
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever taken medications for psychiatric or emotional problems?  Yes       No

When	From whom	For what problem	With what results
_____	_____	_____	_____
_____	_____	_____	_____

Please list any current medications or over the counter drugs your child is taking.

Name	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check the box for all diagnoses that apply to your child, and denote immediate family members who have the following (Mother, Father, Sister, Brother, Aunt, Uncle, etc...)

- |  |  |
|--|--|
| <input type="checkbox"/> Alcoholism _____            | <input type="checkbox"/> Suicide/ Attempts _____           |
| <input type="checkbox"/> Allergies _____             | <input type="checkbox"/> High Blood Pressure _____         |
| <input type="checkbox"/> ADHD _____                  | <input type="checkbox"/> Kidney Disease _____              |
| <input type="checkbox"/> Asthma _____                | <input type="checkbox"/> Liver Disease _____               |
| <input type="checkbox"/> Bowel Disease _____         | <input type="checkbox"/> Physical Abuse _____              |
| <input type="checkbox"/> Cancer _____                | <input type="checkbox"/> Rage _____                        |
| <input type="checkbox"/> Compulsions _____           | <input type="checkbox"/> Schizophrenia _____               |
| <input type="checkbox"/> Depression _____            | <input type="checkbox"/> Suicide/Attempted Suicide _____   |
| <input type="checkbox"/> Diabetes _____              | <input type="checkbox"/> Phobias _____                     |
| <input type="checkbox"/> Drug Abuse _____            | <input type="checkbox"/> Physical Abuse _____              |
| <input type="checkbox"/> Emphysema _____             | <input type="checkbox"/> Psychiatric Hospitalization _____ |
| <input type="checkbox"/> Epilepsy _____              | <input type="checkbox"/> Sexual Abuse _____                |
| <input type="checkbox"/> Heart Disease _____         | <input type="checkbox"/> Thyroid Disease _____             |
| <input type="checkbox"/> HIV _____                   | <input type="checkbox"/> Tremors or tics _____             |
| <input type="checkbox"/> Hormone Disorders _____     | <input type="checkbox"/> Ulcers _____                      |
| <input type="checkbox"/> Learning Disabilities _____ | <input type="checkbox"/> Other _____                       |

Other:

Is there anything else that you feel is important for your therapist to know that we have not asked about on these forms?

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