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.

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

As a general practice, emergency consultation is provided 24 hours each day, seven days a week. In the event you are unable to reach your therapist please call 911, the Crisis Hotline (713-HOTLINE), or go to the nearest emergency room. Your clinician will discuss specific emergency procedures with you in detail. You may reach us at (713)365-9015. If we do not answer in 30 minutes, please call 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

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"

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

Any other characteristics: ____

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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: ____________________

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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…)

- ☐ Alcoholism ____________________
- ☐ Allergies ____________________
- ☐ ADHD ____________________
- ☐ Asthma ____________________
- ☐ Bowel Disease ________________
- ☐ Cancer ____________________
- ☐ Compulsions__________________
- ☐ Depression __________________
- ☐ Diabetes ____________________
- ☐ Drug Abuse __________________
- ☐ Emphysema __________________
- ☐ Epilepsy ____________________
- ☐ Heart Disease ________________
- ☐ High Blood Pressure ___________
- ☐ HIV ________________________
- ☐ Hormone Disorders ___________
- ☐ Kidney Disease ______________
- ☐ Learning Disabilities __________
- ☐ Liver Disease _______________
- ☐ Phobias ____________________
- ☐ Physical Abuse _______________
- ☐ Psychiatric Hospitalization ______
- ☐ Rage _______________________
- ☐ Schizophrenia ________________
- ☐ Sexual Abuse ________________
- ☐ Suicide/Attempted Suicide______
- ☐ Thyroid Disease ______________
- ☐ Tremors or tics ______________
- ☐ Ulcers ______________________
- ☐ 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: ______________