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
In the event of a medical emergency, call 911. Your clinician usually will be available to assist you personally should an emergency consultation be necessary: however, at times, a colleague may cover calls. You may reach us at (713) 365-9015, leave a message and a call back number on your therapist's private voicemail and your therapist will be paged. 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: _____

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: _____

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 please mark all of the items that apply to your child on this list. Feel free to add any others under "Any other characteristics" on the next page.

- ☐ 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 manners, 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 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:

_____
_____
_____
_____

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…)

- ☐ 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?

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____