

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.

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

- Yes No

When	From whom	For what problem	With what results
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Please list any current medications or over the counter drugs your child is taking.

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

Parent/Guardian Signature: _____

Date: _____