1370 Bedford Drive, Suite 106, Melbourne, FL 32940
Phone: (321) 253-8887 Fax: (321) 253-8878

New Child Patient Information – Medication Management

Personal: Date: ____ / ____ / _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Preferred Pronouns: _____

Date of Birth: ____ / ____ / _____ Age: _____

Street Address: _____

City: _____ --___ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Would you like automated appointment reminders sent as a text? Please mark preference.
[ ] Yes [ ] No

Email: _____ May we contact you via email: [ ]Yes [ ] No

Race: _____ Gender: _____ Religion: _____

Pediatrician/Physician: _____

Pediatrician/Physician Phone: ( ) _____ - _____

School: _____ Current Grade: _____

Employer: _____ Position/Title: _____

This form was completed by: [ ] Self [ ] Parent/Guardian [ ] Other: _____

How did you hear about Baytree Behavioral Health? _____

Parent/Guardian Information:

Parent 1 Name: _____ Phone: ( ) _____ - _____

Parent 2 Name:_____ Phone: ( ) _____ - _____

Marital Status: _____ Who Does Child Live With:_____
Please provide custody paperwork & arrangement for parents divorced

Is the child adopted? [ ]Yes [ ]No If yes, are they aware they are adopted: [ ]Yes [ ] No

Are either or both parents' active duty or retired from the Military Service? [ ]Yes [ ]No

Branch: _____ [ ] Active [ ] Retired

Emergency Contact Information:

Name: _____ Relation: _____

Home/Work Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Clinical Information:

Reason for visit:

_____

_____

_____

_____

Education Plan:
Does your child have a current IEP (special education) or 504 Plan? [ ]Yes [ ]No

If yes, what year was it established: _____

Reason for IEP/504 Plan: _____

Previous Treatments:

Hospital/Clinic	Dates	Reason	Outcome

Current Psychiatric Medications:

Medication	Dose	Name of Prescriber	Response

Please bring in a copy of <u>all</u> current medications

Medication Allergies: _____

Child Development Questionnaire:

1. Were there any complications with the pregnancy or delivery of your child? [ ]Yes [ ]No
2. Did your child have health problems at birth? [ ]Yes [ ]No
3. Did your child experience any developmental delays (e.g., toilet training, walking, talking)? [ ]Yes [ ]No
4. Did your child have any unusual behaviors or problems or medical complications (e.g., concussions) prior to age 3 or later? [ ]Yes [ ]No
5. Has your child experienced emotional, physical, or sexual abuse? [ ]Yes [ ]No [ ]Unsure
6. Has your child ever been in court or involved with police? [ ]Yes [ ]No
7. Do you think your child has tried cigarettes, sniffing, vaping, alcohol, or drugs? [ ]Yes [ ]No
8. Is your child socially: [ ]Outgoing [ ]Shy [ ]Depends on the situation.
9. Has your child experienced any bullying? [ ]Yes [ ]No

10. Has your child reported any recent suicidal thoughts, plans, had any suicide attempts, and/or engaged in any self-inflicted behaviors? [ ]Yes [ ]No

11. Is your child involved in any organized social activities (e.g., sports, scouts)? [ ]Yes [ ]No

    List activities: _____

12. Has your child ever been held back a grade? [ ]Yes [ ]No If yes, what grade: _____

    Reason you choose to hold your child back: _____

13. What grades does your child receives at school? _____

14. Do you feel your child is doing the best he/she can at school? [ ] Yes [ ]No

15. Are there any behavior problems at school? [ ] Yes [ ]No

16. Are there any behavior problems at home? [ ] Yes [ ]No

17. Has your child ever previously seen a counselor? [ ] Yes [ ]No

18. Is your child currently taking any medication for a mental health concern? [ ] Yes [ ]No

19. How is your child's current physical health? _____

20. What are your child's favorite activities? _____

21. What are your child's strengths? _____

Baytree Behavioral Health

Orientation to Clinical Services – Medication Management

Following is an outline of items and issues that can impact first clinical meeting, these issues are discussed early in treatment to facilitate a clear understanding of the many factors which influence the clinical work we do together. Anytime you have questions regarding these policies and procedures, please feel free to discuss them with your provider. All of our administrative practices are in compliance with the Health Insurance Portability and Privacy Act (HIPPA).

1. Confidentiality

Confidentiality is essential for the treatment of mental health and is protected by law. Other than emergency situations, information about your care will only be released with your written consent/permission. If treatment is being covered by insurance reimbursement, insurance companies often require information about your diagnosis, treatment plan, and other information as a condition of your insurance coverage. Exceptions to confidentiality do exist and disclosure is required by law:

1. Danger to self - if there is an impending threat to harm yourself, we are required by law to seek hospitalization for you or to contact family members or others who will help provide protection.
2. Danger to others - if there is an impending threat or danger of serious bodily harm to others, we are required to take the appropriate actions, which may include contacting and notifying the potential victim, notifying the police, or seeking hospitalization.
3. Serious disability - if you are unable to meet your basic needs such as clothing, food, medication compliance, and or shelter due to disability to provide your basic needs we may have to disclose information in order to assess the appropriate services.
4. Suspicion of child, elder, or dependent abuse – we must file a report with the appropriate state agency if there is any indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself.
5. Judicial proceedings - Courts may require testimony about your mental health through a court order in some circumstances if you are involved in judicial proceedings. This situation can be rare, and we will make every effort to discuss the proceedings accordingly. We also reserve the right to consult with other professionals when appropriate. In this type of circumstance your identity would not be revealed, and only important clinical information would be discussed. Please note that such consultants are also legally bound to keep information confidential.
6. Other individuals - This can be family members, other doctors, or whomever you want, only with your written consent.

2. Initial Evaluation Session & Routine Follow-Up

During the initial session, your provider will conduct a thorough diagnostic evaluation. An individualized assessment focuses on determining the best treatment plan possible and is

specific for each patient. It is important the initial assessment is comprehensive, and it is important that information about previous medication trails and past psychiatric treatment is provided. Collateral information from sources such as family and school reports can be very helpful for children, adolescents, and even adults. To provide the best possible care a comprehensive assessment is necessary regardless of the treatment method for example, psychotherapy, psychiatric medications, or both. This will allow for the best possible care.

3. Practice Status

Here at Baytree Behavioral Health we have an integration of mental health providers (i.e., psychiatric nurse practitioner, LCSW, psychologists). All records are stored using electronic medical records and your record should only be accessed by your current provider(s). Office staff may at times have to access your record, please note that in accordance with all ethical and legal standards will protect your information. At Baytree Behavioral Health, your provider will work within a network of other professional colleagues such as primary care providers, other specialty physicians, psychologists, social workers, and therapists to assist in your multidisciplinary care.

4. Medication Management

Psychiatric medications can be used in conjunction with psychotherapy to treat many conditions. It is important to find the best combination of medications and therapy for each individual case. It is of vital importance that you understand the target symptoms and expected outcomes. Furthermore, medications come with potential side effects and your provider will always discuss the risks and benefits, government warnings, and alternative treatments (which always includes not using medications) such as homeopathic or therapy with you.

5. Professional Fees

Current fees for services are $250 for an initial psychiatric evaluation. Follow up sessions are billed at $150 for a 15–30-minute visit. Court proceedings and any forensic work (to include required testimony by another party) will be billed at $500 per hour. Furthermore the hourly rate for any out of office proceedings (including depositions and court hearings) will be based on the number of patient hours having to be cancelled to provide this service. Please note these fees are subject to change and will be reviewed and we will do our best to keep you notified of any changes with the financially responsible party.

6. Insurance Reimbursement, Billing and Payments

We are in-network with some insurance plans, and we may be considered out-of-network with others. We do not bill your insurance company directly if we are not in-network. If you have health benefit policies that provide mental health coverage but are out of network with that plan you may be entitled to insurance reimbursement for the provided services. Please feel free

to discuss this with your insurance company by contacting them directly. And we can also provide you with an invoice/receipt (sometimes referred to as a super bill) that you can submit to your insurance company. Please note that most insurance agreements will require you to authorize us to provide them with clinical information directly if reimbursement is being pursued. This can include a clinical diagnosis, historical information, treatment plans or summaries, and sometimes a copy of your chart records. In such cases this information will become part of the insurance companies' files and can be used by them to consider future insurability. You understand that by using your insurance you authorize Baytree Behavioral Health to release such information to your insurance company. We will try to keep that information limited to the minimum necessary. It is difficult to determine exactly how much mental health coverage is available in and it may be necessary to seek approval for ongoing treatment prior to your reoccurring sessions.

Patients are responsible for the payment of their co-pays and deductibles at the time the service is rendered. If the insurance company refuses to pay, the patient is responsible for the cost related to the services. **Costs not covered by primary/second insurance will be the patient/parent's responsibility.**

7. Contacting your provider in an emergency

We always attempt to be accessible for all urgent issues. If your provider is not immediately available by office telephone (321-253-8887), please leave a voicemail with your phone number and we will return your call as soon as possible. If your call is an emergency, please contact 911, go to a local emergency room or hospital, or go to the nearest Baker Act receiving facility immediately instead of calling the office, call the National Suicide Hotline at 988, please 1 if you are a veteran. Hospital providers can contact your provider, so please provide them with our contact information.

8. Cancellations

Often there are patients on a waiting list to see their provider. Subsequently, there is a $50 charge for appointments missed or appointments not canceled within 24 hours of the appointed time. This fee cannot be charged to insurance and is the responsibility of the patient/parent.

9. Professional Records

Mental health records are protected by both law and professional standards. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging to provide you with the full records directly, they are available for you to review with an appropriate mental health professional. We can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such a request.

10. Training Institute

Periodically, we may supervise other mental health professionals in training who may be involved in various aspects of the therapeutic process. Their clinical participation is critical to the development of quality clinicians. They, of course, follow the same rigorous rules regarding confidentiality and your permission is always requested.

11. Telehealth

Baytree Behavioral Health adheres to the guidelines established by HIPAA for the safe and secure administration of therapeutic services through telehealth. All video conferencing applications used by Baytree Behavioral Health are HIPAA compliant and provide end-to-end encrypted transmission for a secure provider-to-patient connection. Protocols are scrupulously followed to ensure that the privacy and confidentiality of each patient is maintained.

12. Treatment of Minors

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify us immediately. We will ask you to provide us with a copy of the **most recent custody decree** that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you're separated or divorced from the child's other parent, please be aware that this is our policy to notify and obtain consent from the other parent before meeting with and or prescribing medication to your child. It is important that all parents are in agreement unless there are exceptional circumstances that their child is receiving mental health evaluation or treatment.

And we may ask to meet with the child's parents/guardians either separately or together during the course of the treatment of your child. Please take note, however, that at all times, our client is your child – not the parents/guardians, other family members, nor the siblings of the child. If we meet with you or other family members in the course of your child's treatment, we will make notes of the meeting in your child's treatment records.

Children must feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents, it is important for children to have a "zone of privacy." This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. It is important to understand that we will provide you with general information about your child's treatment but not share specific information that your child has disclosed to us without your child's agreement. This includes activities and behavior that you would not approve of – or might be upset by – but that do not put your child at risk for serious and immediate harm. However, if there is behavior that the child is showing is high risk and becomes more serious then we will need to use our

professional judgment to decide whether your child is in a serious or immediate danger of harm. If we feel that your child is in such danger, we will communicate this information to you. When there is conflict within the family, particularly conflict due to parental separation or divorce, it is very difficult for everyone, especially for children. Helping to address conflict between the child's parents, our role will strictly be limited to providing treatment to your child. You agree that in any child custody/visitation proceedings neither of you will seek to subpoena our records or ask us to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing our opinion about parental fitness or custody/visitation arrangements.

Please read and sign:

I hereby fully understand that I enter into treatment having discussed the nature of the therapeutic relationship, the therapeutic course, and techniques to be used, to include therapeutic risks and benefits. I am aware of issues relating to confidentiality and its exceptions, patient's rights and responsibilities, the established fees, insurance company requirements, and policies related to “no shows” and cancellations. I have had the opportunity to review the Privacy Act Policies of the clinic and I am also aware that I may discuss these issues at any time. Your signature below indicates that you have read the outpatient treatment agreement which contains information on psychiatric services, medication management, professional fees, billing, insurance reimbursement, contacting providers, professional records, confidentialities, and you agree to abide by its terms during our professional relationship. If we are required to testify in a child custody hearing we are ethically bound not to give our opinion about either parents’ custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a court order is provided. If the provider is required to appear as a witness or two otherwise perform work related to legal matter, the party responsible for his or her participation agree to reimburse the provider at the rate of $500 per hour for time spent traveling speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case related costs.

_____ _____

(Parent/Guardian Signature or Patient Signature) (Date)

_____ _____

(Parent/Guardian Signature) (Date)

Please read and sign:

I hereby fully understand that I enter into treatment having discussed the nature of the therapeutic relationship, the therapeutic course, and techniques to be used, to include therapeutic risks and benefits. I am aware of issues relating to confidentiality and its exceptions, patient's rights and responsibilities, the established fees, insurance company requirements, and policies related to “no shows” and cancellations. I have had the opportunity to review the Privacy Act Policies of the clinic and I am also aware that I may discuss these issues at any time.

_____ _____

(Parent/Guardian Signature or Patient Signature) (Date)

_____ _____

(Parent/Guardian Signature) (Date)

Baytree Behavioral Health Notices of Privacy Practices

I have read and understand Baytree Behavioral Health HIPAA Practices and my rights and responsibilities as they pertain to my treatment record at Baytree Behavioral Health. I am also aware that upon request I may receive a hardcopy of this Privacy Notice.

_____ _____

(Patient Signature) (Date)

_____ _____

(Patient Representative) (Witness)

Benefits & Release:

I authorize the billing of my insurance company for services provided. *(For Medicare/Tricare patients: Your plans are **almost always secondary to any other commercial insurance**. Failure to disclose other insurance is illegal and could result in charges not being covered by either insurance, becoming patient responsibility.)*

[ ] I accept

_____ _____

(Patient Signature) (Date)

Prescription refills require an appointment:

I understand that all medication refills will require an appointment (in-person or virtual).

[ ] I accept

_____ _____

(Patient Signature) (Date)

Patient Financial Policy

No-shows or cancellations with less than 24 hour notice are subject to a $50 minimum fee for the appointment and up to $50 charged per scheduled hour of service.

[ ] I accept

_____ _____

(Patient Signature) (Date)

CONSENT: Charges to credit/debit card on file

Baytree Behavioral Health requires a valid credit card on file for all patients with insurance, co-pays, deductibles, and self-pay patients. This is due to a high incidence of unreported deductibles and the fact that insurance may not cover certain services such as marriage counseling, family counseling and sessions lasting longer than 60 minutes.

By paying via credit/debit card, you acknowledge and agree that this credit card information will be kept on file to be charged for all services that are deemed to be the legal patient's responsibility. These amounts typically include co-pays, co-insurance, and deductibles that have not yet been met or were quoted incorrectly by the insurance company.

Co-pays or any anticipated expenses will be charged to the card on file at the time of the appointment. If the appointment is outside of typical office hours the card will be charged on the next available business day.

In the event that your insurance company notifies us of additional changes, we will notify you of the amount due and, unless other arrangements are made, we will charge the balance due the following business day.

By signing my name below, I authorize Baytree Behavioral Health to keep my credit card on file and to charge my credit card an amount not to exceed $250.00 (if applicable) without my verbal consent. Receipts will be supplied upon request. I have the right to request my credit card be removed via written or verbal request.

THIS AUTHORIZATION EXPIRES 6 MONTHS FROM THE DATE OF OUR FINAL APPOINTMENT.

[ ] I accept

_____ _____

(Patient Signature) (Date)