



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

New Child Patient Information - Therapy

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 all 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

Following is an outline of items and issues which will be discussed in our first clinical meeting. These issues are discussed early in the therapeutic process to facilitate a clear understanding of the many factors which influence the clinical work we do together. They are established to ensure the highest quality of care. Anytime you have questions regarding these policies and procedures, please feel free to discuss them in therapy. All of our administrative practices are in compliance with the Health Insurance Portability and Privacy Act (HIPPA).

1. Confidentiality:

Some exceptions to maintaining confidentiality include:

- Insurance processing (limited information necessary to process claim)
- Discussions with other clinical professionals in private anonymous consultation
- In the case of child abuse
- Suicidal or homicidal plan, action, or intent
- Disclosure of violent crimes or of threat or intent to harm others
- Other individuals, only with your written consent

2. Emergencies:

- Contact the clinic during normal business hours
- Contact the National Suicidal Hotline (800) 273-8255, Press 1 if you are a veteran.
- Go to the nearest Emergency Room.

3. Appointments:

A clinical therapy appointment can be expected to be 45 to 60 minutes in length and I make every attempt to start the appointment on time. From time to time, clinical needs may dictate adjustments, but every effort will be made to avoid delays.

4. 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.

5. Insurance:

If financial conditions make it necessary to adjust service fees or co-pays, the insurance company must be notified of such an adjustment. It is unethical and constitutes insurance fraud if a co-pay is waived without the insurance company's awareness. 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. Baytree Behavioral Health will not bill tertiary insurance for patients. Costs not covered by primary/second insurance will be the patient's responsibility.

6. Training Institute

Periodically, we may supervise 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.

7. 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-client connection. Protocols are scrupulously followed to ensure that the privacy and confidentiality of each patient is maintained.

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.

(Patient 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)

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)