PeaceHealth Medical Group

1200 Hilyard Street, Suite 310
Eugene, OR 97401

Behavioral Health Services, Child History (Age 1-17)

1. Child Information

Date: ___________

Child's full name: _________________________________ Preferred name: ________________________

Birth date: _________________ Gender: ___________________

		Relationship	**Phone number**
Person completing form:	___________________	___________	______________
Person with legal custody:	___________________	___________	______________
Child living with:	___________________	___________	______________
Address:	(Street)	(City, State)	(Zip)

2. Family Composition – Please list all the adults and children in the home where the child is living.

Is this home (check one) ❑ Biological ❑ Foster ❑ Adopted ❑ Other

Name	Birthdate	Relationship	Mental Health Diagnosis?

Is there an open DHS case for this child? ❑ Yes ❑ No

If so, name of DHS caseworker: ___________________________________

Has DHS ever been involved with this child ❑ Yes ❑ No

If so, please provide additional details: ____

____

____

Place patient label here

BH Clinic Note

PeaceHealth Medical Group

1200 Hilyard Street, Suite 310
Eugene, OR 97401

Behavioral Health Services, Child History (Age 1-17)

What are the primary concerns that bring you to treatment? ______________________________
____
____

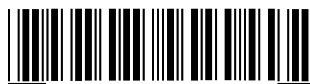
When did these things start to become a problem? ______________________________________
____
____

What things is your child good at? What do they like to do? ___________________________
____
____

3. Has any event occurred during the child's life which has had a profound effect on him/her? (examples: a death, physical, a move, a divorce, loss of job, remarriage, etc.) If so, please explain:
____
____
____
____
____
____
____

4. **Previous Evaluations** (for example; psychological evaluation, academic evaluation, evaluation of disability)
____
WHEN ________________ WHERE ___________________ BY WHOM _______________
What were you told? ____

5. Please list all schools attended including preschool or day care.
____
____
____
____
____



6. What are your goals for treatment?

____
____
____
____
____

MEDICAL INFORMATION

Medical History

YES	NO		YES	NO	
❑	❑	Birth defects	❑	❑	Hearing normal
❑	❑	Head/back injury	❑	❑	Frequent colds
❑	❑	Asthma	❑	❑	Ear infections
❑	❑	Fainting	❑	❑	Stomach complaints
❑	❑	Unconscious	❑	❑	Chicken pox
❑	❑	High temperature	❑	❑	Strep/Staph infection
❑	❑	Seizure	❑	❑	Pneumonia
❑	❑	Vision normal	❑	❑	Diabetes

7. Any complications during pregnancy or birth?
   If so, please describe? ____

____
____
____
____
____

List surgeries or hospitalizations	Date	Age of child

PeaceHealth Medical Group

1200 Hilyard Street, Suite 310
Eugene, OR 97401

Behavioral Health Services, Child History (Age 1-17)

8. Development (Please report age in months or years)
   First word ______________________ First crawled ______________________
   First sentence ______________________ First walked ______________________
   First sat unassisted ______________________ Toilet trained ______________________
   Generally, was development early, later or average? ______________________

9. Any special medical precautions or allergies?
   ____
   ____
   ____

Client Symptom Checklist - Youth

Mark the number of times you experience these symptoms on average in a given week.				
Occurrence of Behavior	**0**	**1-2x**	**3-4x**	**5+**
Aggressive Behavior	❑	❑	❑	❑
Argumentative/Oppositional	❑	❑	❑	❑
Tantrums	❑	❑	❑	❑
Stealing	❑	❑	❑	❑
Bed Wetting	❑	❑	❑	❑
Soiling in inappropriate places	❑	❑	❑	❑
Fidgety, Hyper (can't stay seated)	❑	❑	❑	❑
Crying	❑	❑	❑	❑
Self-Harm (cutting, hitting, banging head on wall)	❑	❑	❑	❑
Lying	❑	❑	❑	❑
Withdrawn	❑	❑	❑	❑
Binging/Purging Food	❑	❑	❑	❑
Negative thoughts about self (I am dumb, stupid, ugly)	❑	❑	❑	❑
Forgetful (chores, homework)	❑	❑	❑	❑
Suicidal thoughts	❑	❑	❑	❑
Thoughts you can't control	❑	❑	❑	❑
Nightmares	❑	❑	❑	❑

Mark appropriate box. Describe if yes.	YES	NO
Problems in school Describe: ______________________	❑	❑
Sadness/Grieving Describe: ______________________	❑	❑
Sexual Trauma Describe: ______________________	❑	❑

Mark appropriate box. Describe if yes.	YES	NO
Night Terrors Describe: ______________________	❑	❑
Property Destruction Describe: ______________________	❑	❑
Fire setting Describe: ______________________	❑	❑
Appetite Disturbance (eating too much or too little) Describe: ______________________	❑	❑
Risk taking behaviors Describe: ______________________	❑	❑
Sleep Disturbance Describe: ______________________	❑	❑
Homicidal thoughts Describe: ______________________	❑	❑
Running away Describe: ______________________	❑	❑
Feeling down or depressed Describe: ______________________	❑	❑
Difficulty with concentration Describe: ______________________	❑	❑
Anxiety Describe: ______________________	❑	❑

Check the statement that best describes your grades.

- ❑ Mostly A's and B's
- ❑ Mostly C's and D's
- ❑ Failing grades

Place patient label here

BH Clinic Note

Child/Young Adult - REGISTRATION INFORMATION

Patient Information:

Date: ______________________

First, Middle, Last Name: ______________________ Preferred: __________

Date of Birth: ______________ SS#: ______________

Gender: __________ Gender Assigned at Birth: __________ Pronouns: ______

Street Address: ______________________

City: ______________ State: __________ Zip: __________

Home Phone: ______________ Work Phone: ______________

Employer: ______________ Position: ______________

PARENT/GUARDIAN

Parent/Guardian Name: ______________________ Preferred: __________

Street Address: ______________________

City: ______________ State: __________ Zip: __________

Home Phone: ______________ Work Phone: ______________

Employer: ______________ Position: ______________

EMERGENCY CONTACT - OTHER THAN PARENT/GUARDIAN

CONTACT NAME: ______________________ RELATIONSHIP: __________

STREET ADDRESS: ______________________

City: ______________ State: ______________ Zip: ______

Home Phone number: ______________ Work phone number: ______________

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: ______________________

SUBSCRIBER NAME: ______________ DOB: ______ Gender: [ ] Male [ ] Female

IF DIFFERENT THEN PATIENT - Relationship: __________ Name on card: ______________

MEMBER ID#: ______________ Group #: __________ Phone #: __________

MEDICAL CLAIMS ADDRESS: ______________________

PeaceHealth

Behavioral Health Services
Patient/Client Provider Responsibility Disclaimer Form

As a client of PeaceHealth Medical Group Behavioral Health Services, you have rights as well as responsibilities. Providers and staff of the department want to make sure your rights are respected and that you are informed about the following:

A clinical record, which is the property of PeaceHealth Medical Group, is maintained documenting all services provided to you by PHMG Behavioral Health providers. This record also contains information that may be received from other sources, including progress notes from physicians and other records that may be obtained with your written consent.

Information contained in the clinical record is confidential and will be released only to persons or agencies outside of PeaceHealth with your written consent (or your parents/guardian if you are a minor). Before giving your written consent to release information, please be sure that you understand what specific information is being requested, the release of information is needed and necessary, and by providing this information it will be beneficial to you.

Please note: There are legal, ethical and organizational policy exceptions to confidentiality, which may require your therapist to release your records. We want you to be fully aware of these exceptions:

As a patient of PHMG Behavioral Health, certain information will be released within the organization; e.g. transcription of notes regarding your visits, charge slips sent to the billing department, communications with physicians or other Behavioral Health providers involved in your care. All employees of this organization are bound by a code of confidentiality. Your health insurance company may reserve the right to review your chart. Care is always taken to protect your rights to privacy. Effort is made to disclose to others the least amount of information needed in order to provide good care and insure reimbursement.

If there is reasonable cause to believe that you are an imminent danger to yourself or someone else, your therapist may arrange for a hospitalization or emergency medical consultation; **notify law enforcement authorities, other family members, and the individuals who may be at risk.**

In the case of a situation of abuse or neglect of a child or vulnerable adult, your therapist may **be required** by Oregon Law to report the situation to the appropriate authorities. If this is a concern for you, please discuss this issue with your therapist.

According to law, if, **at any time** your health status becomes an issue of a legal proceeding, including Worker's Compensation, your therapy records would be subpoenaed. A valid subpoena or court order may require the release of records or testimony by your provider.

If you become involved in legal proceedings or litigation against PeaceHealth, or any of its employees, please be aware that your clinical records may be made available to those involved in the investigation and defense of the organization.

Please initial the following if treatment pertains to a child:

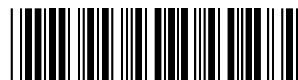
_____ If your minor child is in treatment, be aware that a non-custodial parent who wants to learn about their child's treatment may have the right, as does the custodial parent, to review the child's treatment record and to discuss their child's care with the therapist.

_____ Mental Health services at PeaceHealth Medical Group do not include evaluation for the purpose of resolving legal disputes involving current and previous patients.

If you have specific concerns about confidentiality, please do not hesitate to speak to your provider about them.

I read and understand the above. Client/Guardian initials: __________ **Date:** ___________________

Patient Identification:



Consents

PeaceHealth

PeaceHealth patients (or patient representatives, as appropriate) have the right to…

- Choose from available services in a setting and under conditions that are least restrictive and intrusive to your liberty and that provide the greatest degree of freedom;
- Religious freedom;
- An individualized written service plan and ongoing participation in the planning of services;
- Deny services without informed voluntary written consent except in a medical emergency or as otherwise permitted by law;
- Receive medication only for your individual clinical needs;
- A humane service environment that provides reasonable protection from harm, reasonable privacy and daily access to fresh air and the outdoors. Access may be limited when it would create significant risk of harm to you or others.
- Receive prior notification of involuntarily termination or transfer of services and notification of available sources of necessary continued services;
- Decline to participate in experimentation without informed voluntary written consent;
- Be free from abuse or neglect and to report any incident of abuse without being subject to retaliation;
- Have access to and communicate privately with any public or private rights protection program or rights advocate.
- Know that, to enhance patient safety, video or auditory monitoring may be done in some individual patient rooms, care areas or common areas.

PeaceHealth patients (or patient representatives, as appropriate) are responsible to…

- Participate in planning and decisions regarding your healthcare;
- Provide as accurate and complete as possible relevant medical history, symptoms and concurrent conditions prior to and during the course of treatment;
- Ask questions and inform providers when answers to questions are not clear or understood or if you cannot follow instructions or the treatment plan;
- Promptly report any changes in your health, concerns about their care and/or obstacles to following your treatment plan;
- Provide information necessary to determine the ability to pay for services and any other sources of payment for services;
- Respect the dignity and rights of others;
- Respect the property of other persons and of the medical center;
- Conduct yourself in a respectful way that protects and maintains the safety of the healthcare environment;
- Do your best to follow your agreed upon treatment plan to reach the best possible outcome of care;
- Respect and comply with the PeaceHealth Tobacco-Free Campus Policy.

PeaceHealth

Treatment Plan

You have the right to participate in forming your treatment plan and to ask why any form of treatment is recommended. You may at any time refuse treatment or request a change in the treatment approach. Please discuss this further with your provider.

Appointments & Emergencies

It is your responsibility to attend scheduled appointments. If you cannot keep your appointment, please call and cancel at least 24 hours prior to your scheduled appointment time.

If you have an urgent need during business hours, you may be referred to another Behavioral Health care provider. We typically cannot be interrupted in the middle of a session with another client. On the weekends or after hours, our answering service can locate us, and your call will be returned within 24 hours. If your provider is unavailable, you may be referred to another provider who is on call. In an afterhours emergency, if you can't reach a Behavioral Health provider, go to the Urgent Care Center at PeaceHealth Medical Group or to the Emergency Room at Sacred Heart Medical Center.

Therapy Fees

Our standard hourly fee is $401.00 for psychiatrists, $401.00 for nurse practitioners, $349.00 for licensed psychologists and $349.00 for licensed clinical social workers, psychologist associates and professional counselors.

However, charges will vary depending on the length and type of session (e.g. initial visits, family or group therapy). **The average therapy session is approximately 45 to 50 minutes in length.** You may also be charged for other services such as testing, phone calls, after-hour contacts and consultations with other professionals. Please feel free to discuss charges or fees with us. Your insurance company will be billed for covered services; however, you will be expected to pay for any fees which are not covered by insurance.

Provider Responsibility Disclaimer

I understand many insurance companies now require authorization for mental health services. I will notify my provider if my insurance company requires pre-authorization. It is the provider's responsibility to submit the necessary treatment plans in order to obtain pre-authorization; however, it is my responsibility to be aware of my insurance company's pre-authorization requirements and how many actual benefits I have remaining. Authorization for sessions does **NOT** guarantee available benefits. If my benefits run out, I will be personally responsible for my bill.

Client/Guardian initials: _________ **Date:** ___________________

Health Record Information

I understand my health care provider may enter protected health information related to my treatment into the PeaceHealth electronic record system.

I read and understand the above. Client/Guardian initials: _________ **Date:** ___________________

Risks & Benefits of Therapy

Therapy has both benefits and risks. Therapy has been shown to have benefits such as improved mood or relationships and resolutions of specific problems. Risks may include experiencing uncomfortable emotions such as sadness, anxiety or anger, recalling difficult aspects of your history or disapproval of significant others. There are no guarantees about how therapy will affect you.

PeaceHealth

Grievance Procedures

If you feel your rights have been violated, please discuss this with your provider. If you are not able to resolve the issue in this manner, you may discuss it with the Behavioral Health Manager (458-205-6444) or the Behavioral Health Regional Director (541-686-7376). Finally, if a grievance cannot be resolved in this manner, you should contact the Oregon State Board of Medical Examiners, the Oregon State Board of Psychological Examiners, the Oregon State Board of Clinical Social Workers, the State Board of Nursing or the State Board of Licensed Professional Counselors and Therapists.

Oregon Health Plans Declaration of Mental Health Treatment

The Declaration for Mental Health Treatment is an advance directive that allows consumers to make choices about the mental health treatment they may want to receive at some future time, when and if they are not capable of giving consent. It also lets a consumer appoint a friend or relative to make these choices for him or her. A completed Declaration form allows a doctor to treat a consumer even though the consumer cannot provide consent at the time. Declaration for Mental Health Treatment forms can be obtained by contacting the State of Oregon, Office of Addictions and Mental Health Division (AMH), 500 Summer Street NE, E86 Salem, Oregon 97301-1118. Phone: 541-945-5763 https://www.oregon.gov/oha/HSD/OHP/Pages/Member-Rights.aspx

Oregon Medicaid Clients Only:

❑ I have received and signed a Declaration ❑ I do not wish to sign a Declaration at this time

Client/Guardian initials: _________ **Date:** ___________________

Advance Directive

Advance Directives are available at every PeaceHealth office. Please ask the receptionist for assistance.

I have read and understand the Client Rights and Responsibilities Statement included herein. I give the PeaceHealth Medical Group Behavioral Health Services permission to evaluate or treat me or my family.

I have received a copy of the "Client Rights and Responsibilities" form.

❑ **PeaceHealth Medical Group "Your Rights As A Patient" form given on Admission.**

Signature of Patient/Person Authorized to Sign for Patient | Relationship | Date | Time

Signature of Patient/Person Authorized to Sign for Patient | Relationship | Date | Time

Signature of Patient/Person Authorized to Sign for Patient | Relationship | Date | Time

Signature of Caregiver | EHR User ID | Date | Time

Patient Identification:

PeaceHealth Medical Group SYS1114-OR (03/25/20)

Patient/Client Provider Responsibility Disclaimer - OR

Consents

Financial Assistance Application Form Instructions

This is an application for financial assistance (also known as charity care) at PeaceHealth.

PeaceHealth provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit **peacehealth.org**.

What does financial assistance cover?
The hospital financial assistance covers appropriate hospital-based services provided by PeaceHealth depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance.

In order for your application to be processed, you must:

- Provide us information about your family
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Attach additional information if needed
- Sign and date the form

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail, email or fax completed application with all documentation to: PeaceHealth Patient Financial Services, PO Box 748632, Los Angeles, CA 90074-8632. Email: financialassistance@peacehealth.org Fax: (360) 729-3047. Be sure to keep a copy for yourself.

To submit your completed application in person: Please contact Customer Service for the closest drop-off location at 877-202-3597.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information.

PeaceHealth Financial Assistance Application Form - *CONFIDENTIAL*

Please provide answers to each question. If it does not apply, write "NA". Attach additional pages if needed.

PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632

Guarantor Number

SCREENING INFORMATION

Do you need an interpreter? ❑ **Yes** ❑ **No** *If Yes, list preferred language:* ______________________________

Does the patient receive state public assistance services such as Medicaid, TANF, Basic Food, or WIC?? (OPTIONAL) ❑ **Yes** ❑ **No**

Is the patient currently homeless? ❑**Yes** ❑**No** Is the patient's medical care need related to a car accident or work injury? ❑**Yes** ❑**No**

PLEASE NOTE

- *We cannot guarantee that you will qualify for financial assistance, even if you apply.*
- *Once you send in your application, we may check all the information and may ask for additional information or proof of income.*

PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name		Patient Last Name
❑Male ❑Female ❑Other *May Specify:*	Birth Date		Social Security Number (not required)
Person Responsible For Paying Bill	Relationship To Patient	Birth Date	*Note: You do not have to provide a Social Security number to apply for financial assistance*
Mailing Address			Main Contact Number(s) _____) ________________ _____) ________________
City	State	Zip Code	Email Address:

Employment status of person responsible for paying bill

❑**Employed** *Date of hire:* ❑**Unemployed** *How long unemployed:*

❑**Self-Employed** ❑**Student** ❑**Disabled** ❑**Retired** ❑**Other:**

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** __________ *Use additional paper if needed.*

Name	Date of Birth	Relationship to patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total GROSS monthly income (before taxes):	Also applying for financial assistance?

All adult family members' income must be disclosed and proof included with completed application. Examples of income sources include:

■ Wages ■ Unemployment ■ Self-employment ■ Workers Compensation ■ Disability ■ SSI ■ Child/spousal support ■ Work study programs (students)■ Pension ■ Retirement account distributions ■ Other *Please explain:*

ADDITIONAL INFORMATION

Please use additional pages if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

- I understand that PeaceHealth may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
- I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.
- By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

______________________________ ____________________

Signature of Person Applying Date

If you have questions or need help completing this application: Please contact Customer Service at 877-202-3597. You may obtain help for any reason, including disability and language assistance. To view PeaceHealth's Financial Assistance Policy and additional information, please visit peacehealth.org.

PLEASE MAIL COMPLETED APPLICATION TO PEACEHEALTH, PO BOX 748632, LOS ANGELES, CA 90074-8632