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www.InStep360.org

Registration Packet (Child/Adolescent Version)

Thank you for entrusting In Step Behavioral Health to provide your child or adolescent with mental health services. Please take your time to completely and accurately provide the information requested in this registration packet.

In this document you will find the following forms, each of which must be signed and dated:

- Patient Information
- Assignment of Benefits
- Financial Policy
- Cancellation/No-Show Policy
- HIPAA Communications/Patient Receipt of Privacy Practices
- Health Information

Patient Information

Legal Name: (*Last*) ____________________ (*First*) ____________________ (*MI*) ________

Birthdate: _____/______/______ SSN: __________-________-__________ Sex: Male ☐ Female ☐
MM/DD/YYYY

Address: ______________________________ City/State/Zip: ______________________________

Home Phone (______) ______________ Cell Phone (______) ______________ Work Phone: (_____) ____________

Preferred Number: Cell ☐ Home ☐ Work ☐

Person filling out this form (if different than patient) ______________________________

Relationship to patient ______________________________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE NUMBER: ______________________

PREFERRED PHARMACY: ______________________________ PHARMACY PHONE NUMBER: ______________________

In Case of Emergency Call: ______________________________ Phone: (______) ______________

Relationship to patient ____________________________

Email (will not be distributed to any third parties) ______________________________@__________________

How did you find out about us?

☐ Physician ______________________________ ☐ Online Physician Finder ______________________________

☐ Friend ______________________________ ☐ Search engine ______________________________

☐ Other ______________________________

II. Guarantor Information (Parent or person responsible for account)

Legal Name: ____ SSN: _________-_______-_________

Relationship to Patient: _________________________ Birthdate: ____/____/____ Sex: ☐ Male ☐ Female

Address: ____ City/State/Zip: ___________________________________

Home Phone: (______)______________ Cell Phone: (______)_______________Work Phone: (______)_______________

III. Primary Insurance Information

Policy Holder Name: ______________________________________ Birthdate: ____/____/____ Relationship to Patient: ______________

Insurance Name: ____ NOTE: A copy of this insurance card will be taken at the office.

Employer: ____

IV. Secondary Insurance Information

Policy Holder Name: ______________________________________ Birthdate: ____/____/____ Relationship to Patient: ______________

Insurance Name: ____ NOTE: A copy of this insurance card will be taken at the office.

Employer: ____

Electronic Health Record reporting as requested by the US Government. As a provider that bills Medicare, we must capture this information per Medicare/Medicaid Services. Please note, you do have an option to refuse to report.

Refuse to report ☐

Ethnicity ☐ Latino/Hispanic ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race __________________________

Preferred Language __________________________

I attest the above information is correct. (Sign/Date) ____

ASSIGNMENT OF BENEFITS

I authorize the release of any information including the diagnosis and the records of any treatment/therapy or examination rendered to my child or me during the period of such care to third party payers and/or other health practitioners. I hereby voluntarily consent to care encompassing routine diagnostic procedures and/or medical/mental psychotherapy/medication management treatment authorized by any provider at IN STEP BEHAVIORAL HEALTH, S.C. I authorize and request my insurance company to pay directly to the physician or physician's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services on my behalf or my dependents.

____ ______________________

(Parent/guardian of minor) *Date*

FINANCIAL POLICY

We would like to thank you for choosing In Step Behavioral Health as your mental health provider. We are committed in making your treatment a success by providing you with the care you deserve. As a provider's office, we have certain guidelines to follow for billing procedures. Since the insurance contract is between you and your insurance carrier, it is still **your responsibility** to keep your account up to date and current. It is also your responsibility to supply the office with the correct insurance/billing information.

Insurance Coverage:

It is your responsibility to become familiar with your policy coverage. If a referral is needed, it is to be obtained before the time of first/next visit. If a referral has not been obtained by the time of your visit, the services provided may not be covered you will be required to pay for the visit. We encourage you to call your insurance company before you begin treatment so you can be aware of your payment responsibility. We are participating providers with most PPO's and we will file your claims accordingly. Services rendered at In Step Behavioral Health will be billed from this office. In the event that your insurance does not pay within 60 days of receipt of your claim, we expect the balance pending to be paid by you, the patient. It must be paid in full within 30 days. If you are having difficulty paying your outstanding bill, please contact the billing office to set up a payment plan. Accounts with balances due after that may be forwarded to an outside collections agency for payment. Ultimately, you are responsible for making sure your claims have been paid.

Self-Pay Policy:

If you are a self-paying patient, payment is due at the time of service. This claim will not be billed to an insurance company now or in the future. Once again, it is **your responsibility** to keep your account current.

Our Commitment to you:

We promise to bill your claims in a timely manner to ensure prompt payment by your insurance company. We promise to make the appropriate adjustments to your claim according to your insurance carrier's Explanation of Benefits. We promise to be available to you if you have any questions regarding your account.

Note: For dependents, accounts will be billed to the Guarantor of Record on the account. The office will collect copays from the parent/guardian who is present with the dependent/minor at the time of visit. We will split bills or balances or bill a second party.

For additional information about our practice please utilize our website **www.InStep360.org** or feel free to contact us directly.

Signature: ____ Date: ____________

(Parent/guardian of minor)

CANCELLATION / NO SHOW POLICY

APPOINTMENTS: ISBH requires 24-hour advance notice for cancelation of your appointment. All NO SHOWS or LATE CANCELLATIONS will result in the following fees:

- $110 fee for medication management visits
- $140 fee for Psychotherapy visits.

All NO SHOW/LATE CANCELLATION FEES must be PAID IN FULL prior to scheduling your next appointment.

LATE ARRIVALS: Please notify ISBH if you will arrive more than 10 minutes late for an appointment.

- Late arrivals for a medication management visit may require a reschedule.
- Late arrivals for psychotherapy may reduce your session time.

We normally provide reminder calls as a courtesy, however, it is your responsibility to remember your appointment time and date.

Signature: ____ Date: ____/____/____

(Parent/guardian of minor)

HIPAA COMMUNICATION/PATIENT RECEIPT OF PRIVACY PRACTICES

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding communication:	**YES**	**NO**	**Does Not Apply**
Appointment Confirmations			
Leave message on my cellular/mobile phone			
Leave message on my home answering machine/voice mail			
Leave message with persons at my home			
Confidential Information			
Contact me on my cellular/mobile phone			
Contact me on my cellular/mobile phone*:* *(if unavailable*, may leave confidential information on my voice mail)			
Contact me at home			
Contact me at home: (*if unavailable*, may leave confidential information on my answering machine or voice mail)			
Send sealed confidential information to my home address			
Send sealed confidential information to the address below:			

Address: ____

____

____

I allow/permit the release of information to the following people listed below:	Relationship

____ *Date:* ______________

Patient Signature (including minors aged 12 -17)

____ *Date:* ______________

Parent or Guardian Signature

Patient Receipt of Notice of Privacy Practices

I have received a summary of the Notice of Privacy Practices from my physician or office and have been made aware that I may request a copy of the complete Notice at any time. I am also aware that the notice is available on our website at **www.InStep360.org.**

____ *Date:* ______________

Patient Signature (including minors aged 12 -17)

____ *Date:* ______________

Parent or Guardian Signature

HEALTH INFORMATION

All information will be held confidential in conformance with HIPAA regulation (Health Information Portability and Accountability Act) as enacted by the U.S. Congress in 1996.

Please complete this form to the best of your ability and bring it to the first visit. This information is critical for a thorough and comprehensive diagnostic evaluation.

Family and Household Data

Mother's name ________________________________ Occupation ____________________

Education _____________________ Age _______

Home Phone ___________________________ Work phone ___________________________

Father's name ________________________________ Occupation ____________________

Education _____________________ Age _______

Home Phone ___________________________ Work phone ___________________________

Stepparent's name ________________________________ Occupation _________________

Education _____________________ Age _______

Home Phone ___________________________ Work phone ___________________________

Stepparent's name ________________________________ Occupation _________________

Education _____________________ Age _______

Home Phone ___________________________ Work phone ___________________________

Marital status of parents (circle all that apply)
Single Co-habitating Married Separated Divorced Widowed Remarried

If parents are separated or divorced how old was the child at the time? _____________
If parent(s) or siblings died, how old was child at the time? _______________

Fill out table with household members (including non-relatives) and siblings outside the home.

Name	Relationship to child	Age	Lives at home? (Check if yes)

Primary language used at home _________________

Additional languages spoken ____

Presenting Problem

Briefly describe your child or adolescents current difficulties:

____

____

____

____

____

How long has this problem been a concern for you and when was it first observed:

____

What seems to help with the problem?

____

Have there been prior evaluations or treatment for this or similar problems? _______________

If yes, when and with whom? ____

List any current medications the child/adolescent is currently taking
____

Social and Behavior Checklist

Circle the specific terms that currently apply to the child/adolescent:

Difficulty with speech, hearing, language, vision, coordination, clumsiness.

Prefers to be alone, shy or timid, gives up easily, does not get along with siblings/peers, more interested in things than people.

Aggressive, teases/harms animals, plays with fire, stubborn, dangerous to self/ others, engages in risk-taking behavior.

Much too active, has frequent tantrums, rocks back and forth, holds breath, bangs head

Frequent nightmares, trouble sleeping, eats poorly, poor bladder control, wets bed, bites nails, sucks thumb.

Special fears, habits, mannerisms, blank spells, slow to learn, impulsive.

Other____

____

____

Educational History

Please mark the child/adolescent's current concerns:

Has difficulty with reading _____ Has difficulty with math _____

Has difficulty with spelling _____ Has difficulty with writing ______

Difficulty with other subjects (describe) ____

Does not like school ______

Does your child/adolescent have an IEP or Section 504 plan? Please provide details, including eligibility category:

____

Has child/adolescent been held back a grade (retained) and, if so, why

____

Describe services or interventions in school, if applicable

____

Developmental History

During pregnancy describe the following or mark N/A:

Medication(s) taken by mother, if applicable _____________________________________

If smoking, how many cigarettes/day ______________

If drinking alcoholic beverages, how much per day _______________________

Other drugs taken, amount and frequency _______________________________________

Were forceps used during delivery? __________ Birthweight ____________________

Was Caesarian section performed and, if so, for what reason ________________________

____

Was child/adolescent premature and, if so, by how many weeks

____

Describe birth defects or complications, if any ____________________________________

____

Describe feeding problems, if any ____

____

Describe sleeping problems, if any ____

____

Was the child/adolescent quiet as an infant? _________

Did the child/adolescent like to be held as an infant? ____________

Was the child/adolescent alert as an infant ?__________

Describe any special problems in the growth and development of the child/adolescent____

____

____

____

At what age did the child/adolescent demonstrate each of the following behaviors? Please add a question mark next to the ages you are approximating. If you don't remember, place only a question mark.

Showed response to mother _____ Babbled _____ Rolled over _____

Crawled _____ Spoke first word _____ Sat alone _____

Put several words together _____ Stayed dry at night _____ Was toilet trained _____

Fed self _____ Walked alone ______ Dressed self _____ Rode tricycle _____

Medical History

Note age or age range during which child/adolescent had any of the following illnesses or conditions.

Allergy ________________ Anemia ________________ Asthma ________________

Bleeding problems _______________ Bone or joint disease ____________________

Broken bones _______________ Cancer ________________ Chicken pox _________________

Convulsions ________________ Diabetes ________________ Dizziness ________________

Difficulty concentrating ______________ Diphtheria _______________

Eczema or hives _____________ Epilepsy _______________ Encephalitis __________________

Extreme tiredness or weakness ________________ Fainting spells _________________

Frequent or severe headaches _________________ German measles ________________

Gonorrhea or syphilis ______________ Hay fever _______________ Heart disease _____________

High blood pressure ______________ High fever _______________

Hospitalizations _______________ Injuries to head _______________ Ear problems (disease, infection, injury or impaired hearing) _______________ Jaundice/hepatitis ________________

Loss of consciousness _______________ Measles ________________ Mumps ______________

Meningitis_______________ Memory problems _______________ Paralysis ________________

Operations _______________ Rheumatic fever ________________

Scarlet fever _______________ Suicide attempt _______________ Self-injury ______________

Tuberculosis ___________ Whooping cough ______________ Visual problems ______________

Other (describe) ____

Family Medical History

Check illnesses or conditions applicable to child/adolescent's immediate family and note relationship.

Condition	Relationship to Child
Alcoholism _____	____________________________
Cancer _____	____________________________
Diabetes _____	____________________________
Heart trouble _____	____________________________
Nervous or psychological problem _____	____________________________
Depression _____	____________________________
Suicide attempt _____	____________________________
Learning disability _____	____________________________
Drug abuse/addiction _____	____________________________
Other _____	____________________________

Additional Information

What are the child/adolescent's favorite activities?

____

____

____

____

What activities would the child/adolescent like to engage in more frequently than he/she does at present?

____

____

What activities does the child/adolescent like the least?

____

____

Has the child/adolescent ever been in trouble with the law and, if so, please briefly describe.

____

____

____

What do you do when your child/adolescent behaves inappropriately? Check all responses that apply.

Ignore problem behavior _____ Time out _____ Scold child ______

Tell child to sit on chair _____ Spank child _____ Threaten child _____

Reason with child ______ Redirect child's interest ______

Send child to his/her room ______ Take away some activity or food ______

Don't use any technique ______ Other (describe) ________________________________

Which disciplinary actions, and for what problems, are usually effective? __________________

____

Which disciplinary actions, and for what problems, are usually ineffective? _________________

____

What have you found to be most satisfactory way of helping the child/adolescent?

____

____

What are the child/adolescent's strengths?

____

____

Please share any other information that you think will be of help in working with the child/adolescent.

____

____

____

____

____