Kidspiration

Pediatric Therapy Services

Outpatient Behavioral Health Services

****New Client Orientation Packet****

Welcome to Kidspiration and thank you for choosing us for your outpatient behavioral health needs. Kidspiration is CARF accredited and provides comprehensive discipline services. We are committed to the overall needs of client care and the entire client system.

Kidspiration Mission Statement

Our well-trained and supportive staff will give your child the best possible care by providing exceptional therapies and classroom curriculum designed specifically to maximize your child's abilities!

Kidspiration Locations:

Mountain Home Branch:

Hours of Operation: 8am-4:30pm

1310 Bradley Drive

Mountain Home, AR 72653

Phone: (870) 424-4021

Fax: (870) 424-4112

Yellville Branch:

Hours of Operation: 8am-3:30pm

81 Developmental Dr

Yellville, AR 72657

Phone: (870) 449-7050

Fax: (870) 449-4020

Behavioral Health After Hour CRISIS Line: (870) 321-1027

Call 911 for ALL MEDICAL EMERGENCIES

All Outpatient Behavioral Health Services must be deemed medically necessary. The Mental Health Professional (MHP) assigned to your child will be your primary contact for care coordination. Communication with MHP's can be scheduled by appointment. Phone calls may be limited due to client service and staff safety procedures. This person can help with the following information:

- Understanding treatment options and rules. Treatment will vary by program and diagnosis. Rules may vary, but fighting, threatening, profanity, sexual activities, gambling, and stealing are not allowed.
- Standards of Professional Conduct related to our services including boundaries with clients.
- Responses to the identification of any potential risks to you or your child.
- If requested, your MHP will provide you with a copy of the Kidspiration OBH agency rules.

Outpatient Behavioral Health Services:

Every child who is deemed medically necessary to receive Outpatient Behavioral Health Services will receive at minimum individual, family, and psycho education services with their MHP.

- Currently Kidspiration OBH has two full time therapists Lacie Stowe, and Erin Geyer both have their Master Degree in Social Work and are licensed with the Arkansas Social Work Board. Lacie (LMSW) and Erin (LCSW) are both certified in PCIT, AUTPlay, TF-CBT, and DC: 0-5 Assessment and Diagnostic.
- At the discretion of the OBH therapist specific therapy interventions available through Kidspiration OBH include:
    - **Parent Child Interaction Therapy (PCIT)**
        - PCIT is an evidence-based behavior parent training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT.
    - **AUTPlay**
        - AUTPlay is an integrative family play therapy framework. AutPlay is a neurodiversity paradigm informed and designed to help address the mental health needs of neurodivergent children ages 3-18 (including autistic children, those with ADHD, social anxiety, sensory differences, learning differences, and developmental and physical disabilities).

- **Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)**
  - TF-CBT is an evidence-based treatment approach shown to help children, adolescents, and their parents (or other caregivers) overcome trauma-related difficulties, including child maltreatment. TF-CBT helps children address distorted or upsetting beliefs and attributions and learn skills to help them cope with ordinary life stressors. It also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.
- **DC: 0-5 Diagnostic Assessment**
  - The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) is an age-appropriate approach for assessing infants, toddlers and preschool children. This tool classifies mental health and developmental disorders in children from birth through five years old considered in relationship to their families, culture and communities.
- **Crisis Intervention**
  - Crisis interventions and Emergency Response are provided to OBH clients regardless of their ability to pay for services, and will not vary based on the client's funding source. Crisis is identified as a threat to self, or others. Crisis intervention services will be at the discretion of the responding therapist. Crisis Intervention is identified as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
- **Group Therapy**
  - Group therapy focuses on the development of social and emotional skills, and the interactions between peers. At Kidspiration group therapy is utilized within the EIDT as a Kindergarten preparation component for therapy clients.

Assessment and Treatment Planning

During your mental health assessment, your MHP will work with you to identify specific needs your child has to determine service eligibility, and determination of Serious Mental Illness (SMI), and Serious Emotional Disorder (SED) if any. You and your therapist will develop a care plan together. To make progress and continue in care your participation is essential. The assessment process is ongoing throughout the entirety of your child's treatment which includes the ongoing assessment for service eligibility, and determination of Serious Mental Illness (SMI), and Serious Emotional Disorder (SED) if any. The treatment plan will be reviewed regularly with you to assess goals and progress made. As needed the plan may require specific adjustments. The MHP will always include you in on any changes or adjustments to your child's treatment plan.

Insurance and Payment

Kidspiration Outpatient Behavioral Health is required to bill Medicaid for services provided to Medicaid recipients, we do not need permission to do so. Due to the many children who need our services and money is limited, we are required to make use of all possible sources of funding to meet the needs of the children. The first source of funding is your families private health insurance/HMO and/or Medicaid first, then we are unable to seek funding from other sources. If you decline billing of your families private health insurance/HMO and/or Medicaid, you may be responsible for the entire cost of your child's therapy services. Access to your private health insurance/HMO benefits by Kidspiration should not pose a realistic threat that you or your child will suffer a loss of insurance/HMO benefits. Access to your insurance/HMO will only be done with your approval. The patient shall be financially responsible for any portion of the invoice that is not paid, except in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts that Kidspiration may reasonably request to ensure that all third party benefits for therapy services are paid. Your voluntary permission is required for Kidspiration to submit a claim to your insurance/HMO carrier. Kidspiration OBH services may be denied based on third-party payer's policies or rules. If your insurance is denied or found inactive, you are responsible for paying for the services rendered. Before services are rendered the caregiver is required to complete and sign the consent for billing, and responsibility of charges. Prior to services being rendered, your child's Medicaid insurance must be active, or you must pay for the services based on your HMO requirements for deductibles or copays.Third party OBH service payments may be denied based on the third-party payer's policies and/or rules. Documentation of payment will be kept in the clients file, that is up-kept by the medical records librarian.

Safety

Kidspiration uses a variety of methods to ensure safety and support of all clients. OBH will ensure that no client is left unattended or secluded while in their care. Seclusion and restraint is not used within the Kidspiration facility or OBH department. Our company uses Crisis Prevention Intervention (CPI) verbal de-escalation techniques as needed with our clients. All Kidspiration staff are trained during onboarding and annually in verbal de-escalation techniques which are used with any individual in crisis. CPI is a safe way to de-escalate acting out clients that become a risk to self or others. Kidspiration OBHS does not utilize seclusion, restraint, and/or stabilization (holds) with any client. As necessary, your therapist will implement a safety plan with you and your child to ensure that all safety precautions are taken.

Tobacco Policy: Both Kidspiration facilities and grounds are tobacco free. No vaping devices are allowed. Information is available upon request about tobacco cessation.

Weapons Policy: ABSOLUTELY no weapons of any kind are allowed on or inside Kidspiration grounds.

Alcohol and Drug Policy: Alcohol, illegal drugs and drugs not prescribed by a doctor to the specific client are not permitted on Kidspiration property. Any illegal drugs or alcohol found will be confiscated and the police will be called.

Prescription and Over the Counter Medication Policy: Properly identified, state compliant labeled, and physician ordered medication brought into Kidspiration may be administered by the Kidspiration Nurse only. All medications will be locked in a medication box and held within locked cabinets in the medical office.

Mandated Reporting

Kidspiration service providers are mandated reporters and bound by policies and procedures. Our job at Kidspiration is to fully protect the client, as well as the law to report any instances of suspected abuse or neglect of a child or adult.

Suspension of Care Policy

Kidspiration may choose to deny care or treatment to your based on the following:

1. Treatment impasse or lack of continued progress or pattern of noncompliance.
2. Overly aggressive, hostile, rude, belligerent, or threatening behaviors towards staff or visitors.
3. Conflict of interest or dual relationships which may impair the therapeutic process.

Transition/Discharge Criteria

Once client goals have been met, you and your treatment team will evaluate the plan for a possible change in focus, and/or a decrease in the level of care you are receiving. A transition or discharge process may take place if necessary.

Satisfaction or Dissatisfaction

We at Kidspiration OBH would love to hear from you on all the positives and negatives. Kidspiration OBH is always looking for ways to improve their services. The OBH department will send out Satisfaction Surveys Quarterly to continuing clients. Your feedback is essential to providing the best services possible. If desired these surveys may be completed anonymously. At any time you may also discuss any concerns, questions, and/or support with your therapist, other OBH staff, supervisors, or the CEO. There is also a suggestion box in each Kidspiration facility in which information can be placed. Information from surveys will be collected and used to improve services, make improvements, and overall learn as we continue to grow our department.

Appointment Policy

Please be courteous when scheduling and maintaining appointments. Clients that arrive 15-20 minutes late to a scheduled appointment will be asked to reschedule due to the respect and proper care of other clients. We schedule many appointments back-to-back during the day and need to provide the proper level of quality to each of our clients. Appointments not canceled at least 24 hours in advance are considered a No-show. If you No-show two times in a 3-month period, we may limit rescheduling your appointments. Certain scheduling conditions may be created to assist the therapy process and overall client care. **Discharge after three (3) No-Show appointments (individual and/or family) in a two (2) month period will occur at the discretion of the MHP.**

Privacy Practices and Medical Records

We maintain secure client records whether they are in paper or electronic form. We are mandated by law to protect all medical records to protect the client system. You have specific privacy rights that protect the confidentiality of your health information and are entitled to your medical record, so long as your health and safety are not jeopardized. Discussion of privacy rights may take place with our director during an organized meeting. Medical record release will only take place as followed by required state laws. If you have any questions about your privacy practices or medical records, please contact the Kidspiration Medical Records Librarian or director.

Client Responsibilities

- **Medicaid Services** –
  - Attend the intake and complete all necessary forms.
  - Obtain a PCP referral, and complete yearly "well child check" for children's services.
  - Make and keep mandatory Medicaid Physician assessment appointments.
  - Participate in family therapy, for children's services.
- Take all medications as prescribed.
- Keep appointments and notify your practitioner when you are unable to do so.
- Follow all applicable policies affecting your care and conduct.
- Be considerate of the rights of others and assist in noise control.

Client Rights

- Translation services and communication needs of those with vision, speech, hearing, language, and cognitive impairments.
- Every client has freedom from retaliation and humiliation, informed consent or refusal or expression of choice regarding delivery, release of information, and composition of service delivery team.
- Consent to the treatment provided.
- Receive treatment regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Receive necessary care so long as it is available or referred where it may be received.
- Receive care that respects personal dignity, values, and beliefs.
- Continue to have legal rights to conduct personal business.
- Know the name and qualification of the staff member providing your or your loved one services.
- Help in deciding what treatment is needed. For individuals under 18 a legal guardian will be expected to help.
- To understand treatment and rules that must be followed, and service limitations.
- Treatment choices when available including risk and benefits of each.
- When necessary, discharge planning.
- If medication is needed, an understanding of the medication, risk, benefits, and side effects.
- To be provided an understanding of services in a way that is easy to understand. To be informed about progress and outcomes of care.
- To know when and why services are/may be changed from one provider to another.
- To know why a referral to a new program is made, and assistance with any other referral requested.

- Confidentiality about treatment, including what is said to staff and recorded in the medical record.
- To review the organization's rules and regulations.
- To make formal or informal complaints as needed.
- Access to protective and advocacy services.
- To be free of any mental, physical, sexual, and/or verbal abuse, neglect, or exploitation

Helpful Resources

- DHS of Baxter County (870) 425-6011
- DHS of Marion County (870) 449-4058
- Child Abuse Hotline (800) 482-5964
- Sexual Assault Center (877) 432-5368
- Arkansas Crisis Center (888) 274-7472

- National Council on Alcoholism and Drug Dependence (NCADD): 1-800-NCA-CALL (622-2255)
- National Institute on Drug Abuse (NIDA): Call 1-800-662-HELP (4357)
- National Poison Control Center: 1-800-222-1222
- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Alcoholics Anonymous: 1-212-870-3400
- National Drug Helpline: 1-888-633-3239
- Adult Protective Services: 1-800-482-8049
- National Domestic Violence Hotline: 1-800-799-7233

Medicaid Resource:

- Connect Care (to have PCP assigned): 866-854-8788
- MCD transportation (if you need transportation for your appt): 800-275-1131 (48 hours notice required)
- PASSE customer service info (for questions about services covered, or to contact your care coordinator):
- Arkansas Total Care: 866-282-6280
- Empower: 866-261-1286
- Summit: 844-405-4295
- PASSE Ombudsman office: 844-843-7351

Grievance and Complaints

All grievances and complaints are handled by Kidspiration director, Leah Coleman.

1. You may call the center at (870) 424-4021 and schedule an appointment to speak with Leah Coleman regarding your grievance or complaint.
2. You may mail a written complaint to Kidspiration of Mountain Home with attention to Leah Coleman.
3. You may visit our center in Mountain Home and file a formal complaint which will be given to Leah Coleman to process and handle.
4. Any individual wishing to complain may due so formally to the organization and/or Grievance Officer Leah Coleman, CEO.
5. Any individual may complain without fear of retaliation or barrier to services.

Kidspiration Outpatient Behavioral Health 24-hour Crisis Line:

If we have a client of record for behavioral health and an after-hour crisis takes place, this crisis number will be available during any time the business is closed. Crisis number **(870) 321-1027**. If the main number is contacted after hours, there will be a default voicemail reflecting the after hour behavioral crisis number and specific steps to follow regarding the crisis. If the crisis line is called, a licensed mental health professional will take the call or return the call as quickly as possible. The licensed mental health professional will be required to respond within 15 minutes of the emergency/crisis call, and a crisis assessment may be required after the call. If a return call/contact cannot be made within the 15-minute response time the reason will be documented. The crisis phone also has a specific voicemail denoting what protocol to follow regarding the specific call and that a licensed mental health professional will call you back as soon as possible. A mental health professional will be available 24/7. During the intake, all clients are presented with a full intake packet which lists the crisis number. The MHP will cover all aspects of the crisis line during the assessment as well. The crisis number is also listed at all entrances of the facility.

If an after-hours crisis should take place, the mental health professional (MHP) and Clinical Director will help determine what necessary steps may be taken next, whether it is contacting medical professionals or other specific advice for safety measures. Within 24 hours the clinic will have a formal meeting with the behavioral health crisis team to debrief the call and assure proper steps were taken and implement any necessary changes. Any request from law enforcement or local hospitals that require emergency behavioral health, a member of the Kidspiration Outpatient Behavioral Health team will arrange a face-to-face assessment within two (2) hours. The specific client that made the call will be required to follow up with the designated MHP as soon as possible. An after-hours care plan may be subject to take place depending on the severity/outcome of the crisis at hand.

- Development of support systems both pre and post events, are available to support staff and clients to continue daily operation routines. These include but are not limited to:
- Access to existing sources for treatment (phone, internet based)
- Immediate crisis intervention by a licensed MHP, including a range of modalities
- Telehealth capacities such as disaster calls and other emergency ways of connection with clients at home/community
- Ability to give support at home by MHP's.

Kidspiration
Pediatric Therapy Services
Phone: (870) 424-4021 Fax: (870) 424-4112

Planned Annual Agency Closures

- New Years Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving (Thursday and Friday)
- Christmas Eve
- Christmas Day

All closures will be listed on KTLO, Baxter Bulletin, and posted to our Facebook pages.

Inclement Weather Policy

During inclement weather, traveling to and from either Kidspiration location may become hazardous. Please consider your own safety when deciding to keep your appointment. Please call to confirm that your provider is present or if you are unable to make it due to weather conditions. Kidspiration follows local public school closing policies. Please check KTLO or Baxter Bulletin to confirm school closing, information will also be posted to our Facebook pages.

Kidspiration Outpatient Behavioral Health Services

Informed Consent for Assessment and Treatment

Client Name: _____ Date of Birth: _____

I certify that I have been given and provided an understanding of the **Kidspiration Outpatient Behavioral Health New Client Orientation packet.** I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several months. I understand that at any time I may request a copy of OBH service rules.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time but agree to discuss this decision with my provider first.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the individual, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such a request.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations and discuss with your provider any questions or concerns you may have. If you need another copy of the Privacy Practices, please contact the Kidspiration office or your MHP.

Kidspiration Outpatient Behavioral Health Services

By my signature below, I voluntarily request and consent to the outpatient behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client or Legal Guardian Signature: Date

_____ _____

Witness Signature: Date

Kidspiration Outpatient Behavioral Health Services

CONSENT FOR BILLING

We are pleased to be able to provide services to your child. Because there are so many children who need our services and money is limited, we are required to make use of all possible sources of funding to meet the needs of children. The first source of funding is your family's private health insurance/HMO and/or Medicaid first, then we are unable to seek funding from other sources. If you decline billing of your family's private health insurance/HMO and/or Medicaid, you may be responsible for the entire cost of your child's therapy.

Access to your private health insurance/HMO benefits by Kidspiration should not pose a realistic threat that you or your child will suffer a loss of insurance/HMO benefits. Access to your insurance/HMO will only be done with your approval. The patient shall be financially responsible for any portion of the invoice that is not paid., except in the event of covered services provided to Medicaid recipients. The undersigned agrees to execute any and all documents and perform any acts the Kidspiration may reasonably request to ensure that all third-party benefits for therapy services are paid.

Your voluntary permission is required for Kidspiration to submit a claim to your insurance/HMO carrier, please check the appropriate box below and sign this form. With your signature, you authorize direct payment of medical benefits to Kidspiration and that you understand that you are personally responsible to the Kidspiration for charges not covered or paid for by your insurance/HMO.
We are required to bill Medicaid for services provided to Medicaid recipients. We do not need permission to do so.

Child's name _____
Child's Date of Birth: _____
Parent/Guardian Name: _____
Relationship to Child: _____

Please check all the apply:

o I give my permission for Kidspiration to bill my private insurance/HMO for services provided to my child by the program. I hereby agree to pay copays and deductibles. (If co-pays and deductibles are a financial hardship please see the office manager for assistance). I also authorize release of medical information necessary to process this claim.
o I have Medicaid coverage for my child.
o I do not have any form of insurance coverage or Medicaid.
o I have private insurance/HMO coverage, but I DO NOT want Kidspiration to bill my private insurance company or HMO and understand that I may be responsible for the cost of my child's therapies.

Signature:_____ **Date:**_____

Please make sure we receive a copy of your insurance card and/or ID upon arrival at your first visit. Kidspiration will file claims with up to two insurances on your behalf; you will be responsible for filing any additional claims. We will verify your insurance coverage before your initial evaluation and inform you of your child's benefits at your first visit. This is not a guarantee of benefits. If you have an insurance copayment it will be collected when you sign in at each visit.

Kidspiration Outpatient Behavioral Health Services

Authorization for Release of Confidential Information:

I hereby authorize and request: _____ to furnish all information concerning my history, treatment, examinations, hospitalizations, etc. including copies of medical records to: _____.
I, _____, the parent of the patient named below, give Kidspiration Pediatric Therapy Services, Inc. permission to obtain from or give to the above-named agency/person pertinent, social, medical, or other information as listed below. I understand that this information is confidential and will only be used for the benefit of this patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of Kidspiration Pediatric Therapy Services, Inc. and that Kidspiration Pediatric Therapy Services, Inc. is in no way responsible for this action. I further understand that this consent form is valid for the duration of the patient's treatment, and I may revoke this release at any time by requesting this in writing and submitting to this office.

Documents to be released:

___ Medical evaluation and/or medical record

___ Psychological Evaluation

___ Educational IEP or IHP

___Occupational, Physical, Speech Therapy Evaluations & Goals/Treatment Plan

___ Other: _____

Purpose for release:

___ At request of the parent/guardian

Other: _____

Patient's Name: _____ DOB:_____

x _____ _____
Signature of Legally Responsible Adult Relationship & Date

Kidspiration Outpatient Behavioral Health Services

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Kidspiration is required by law to maintain the privacy of your child's health and education information to provide you a notice of our legal duties and privacy practices, and to follow the information practices that are described in this notice. Kidspiration respects your privacy. We understand that your child/family's personal information is very sensitive. For example, your child's personal information includes demographics, treatment plans, documentation of diagnosis, and treatment records. By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Kidspiration. Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notices of Privacy Practices are subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website or contacting us directly. I understand that at any time I may request a copy of OBH service rules

** If you have any questions about this notice, please contact Kidspiration at (870) 424-4021**

I acknowledge receipt of the Notices of Privacy Practices of Kidspiration

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Relationship to child: _____

x _____ _____

Signature of Legally Responsible Adult Date

Kidspiration Outpatient Behavioral Health Services

POLICY FOR INSURANCE PARTICIPANTS

We are filing your insurance through a contracted plan. It is your responsibility to provide us with the correct insurance information and include a current identification card **BEFORE SERVICES ARE RENDERED**. Should you not have your insurance card with you at the time of your appointment, you will be required to either pay in full for services performed or reschedule your appointment so that you may obtain the insurance card.

It is also your responsibility to provide your insurance company with a completed "Coordination of Benefits" form at the beginning of each calendar/benefit year. You may obtain this form from your insurance company.

DEDUCTIBLES AND COPAYMENTS WILL BE COLLECTED AT THE TIME OF SERVICE. WE WILL BILL YOUR INSURANCE COMPANY FOR THE BALANCE UNDER THE PLAN PROVISIONS. WE HONOR ALL OF OUR INSURANCE CONTRACTS AND TAKE ADJUSTMENTS AS INSTRUCTED BY OUR PAYORS. AFTER YOUR INSURANCE PAYS AND REQUIRED ADJUSTMENTS ARE APPLIED, YOU WILL RECEIVE A STATEMENTS FOR ANY REMAINING BALANCE THAT IS YOUR RESPONSIBILITY PER YOUR INSURANCE PLAN. PROMPT PAYMENT IS EXPECTED AND APPRECIATED AND MUST BE RECEIVED PRIOR TO SCHEDULING ANY FUTURE APPOINTMENTS

It is your responsibility to follow up with your insurance company to be sure that all of your claims have been processed and paid to us for services performed.

By signing below

- ☐ I understand and agree to the above stated policy
- ☐ I understand that I am responsible for my co-payment and/or deductible at the time services are performed if applicable.
- ☐ I understand that at each visit I am to inform this office of any changes of insurance, addresses, phone numbers, etc. If I do not, and the insurance is filed incorrectly as a result; I understand that I am responsible for the charges incurred.
- ☐ I grant permission for Kidspiration to collect payment due from my insurance company for services performed.
- ☐ I understand that third party OBH service payments may be denied based on the third-party payer's policies and/or rules.

_____ _____ _____

Signature of parent/Guardian Printed Name Date

Kidspiration Outpatient Behavioral Health Services

PATIENT INSURANCE INFORMATION FORM

(Please bring a copy of your insurance card with you)

Name of Insurance Company:_____

Address:_____

City/Street/Zip:_____

Insurance Co. Phone Number:_____

Patient Relationship to Subscriber:_____ Subscriber's Soc. Sec#_____

Subscriber's Full Name:_____ Subscriber's DOB_____

Subscriber's Address:_____

City/Street/Zip:_____

Subscriber's Phone Number:_____

Subscriber's Employer Name:_____

ID/Policy #:_____ Group #:_____ Co-Pay Amount $_____

Name of Secondary Insurance (if applicable)_____
Subscriber's Name_____ Group # _____ Policy # _____
Guarantor (Person Responsible for Payment):_____

If different than Patient or Subscriber, please provide information below.
Patient Relationship to Guarantor:_____ Guarantor's Soc. Sec# _____
Guarantor's Full Name:_____ Guarantor's DOB _____
Guarantor's Address:_____
City/Street/Zip:_____
Guarantor's Phone Number:_____
Guarantor's Employer Name:_____

_____ _____ _____

Guarantor's signature Print Name Date

Kidspiration Outpatient Behavioral Health Services

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Kidspiration is required by law to maintain the privacy of your child's health and education information, to provide you with a notice of our legal duties and privacy practices, and to follow the information practices that are described in this notice. We respect your privacy. We understand that your child and family's personal information is very sensitive. For example, your child's personal information includes demographics, treatment plans, documentation of diagnosis, and treatment records. Described as follows are the ways we may use and disclose information that identifies your child.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Treatment: We will use health information to provide treatment to your child. This includes use and disclosure of health information among KIDSPIRATION staff and volunteers as it relates to your child's treatment. In addition, with your written consent, we may disclose health information to your child's doctors, nurses, technicians, or other personnel, including other people who are involved in your child's medical care.

Payment: With your authorization, we may disclose health information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services your child received. For example, we may provide your health plan with information including diagnosis, procedures performed, progress goals, or recommended care, so they will pay for your child's treatment.

OTHER USES AND DISCLOSURES

We may also use or disclose your child's information to meet special reporting requirements, for public health reasons, or for other purposes. Such disclosures permitted by law that do not require your written consent include:

§ Family and friends involved in your child's care or payment.

§ Disclosures to public health authorities to prevent or control disease.

§ Disclosures to public authorities as part of a report of child abuse, neglect, or domestic violence.

§ Data for health or educational oversight activities, such as audits, investigations or inspections.

§ To avert a serious threat to health or safety or to prevent serious harm to an individual.

§ To secure emergency medical treatment for your child in the event of an accident or injury.

§ Participation in a qualifying research project

§ As required by law, such as for law enforcement or in response to a lawful subpoena or court order.

§ Coroners or medical examiners, as necessary, to carry out their duties.

§ To provide you with information about treatment alternatives or new health-related services that may be of interest to you

§ Appointment reminders

All other uses and disclosures will be made ONLY with your written authorization, which you have the right to revoke in most cases.

YOUR RIGHTS

You have the following rights regarding health and education information we have about your child:

Right to Inspect and Copy: You have a right to inspect and copy health information that may be used to make decisions about your child's care or payment for your child's care. This includes medical and billing records, other than psychotherapy notes. To inspect a copy of this health information, you must make your request in writing to our Executive Director.

Right to Amend: If you feel that the health or education information we have is inaccurate or misleading, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for KIDSPIRATION. To request an amendment, you must make your request in writing to our Quality Assurance Coordinator. While we accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures and a record of access regarding your child's health and education information. The list does not include disclosures we made directly to you, disclosures to friends/family members, disclosures you specifically authorized in writing, disclosures to third party payers or disclosures related to our daily business operations. To request an accounting of disclosures, you must make your request in writing to our Executive Director.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose. You also have the right to request a limit on the health information we disclose to someone involved in your child's care or the payment for your child's care, like a family member or friend. To request a restriction, you must make your request in writing to our Executive Director. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide your child with emergency treatment.

Kidspiration Outpatient Behavioral Health Services

Right to Request Confidential Communication: You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Please contact our Executive Director to request confidential communication. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. This new notice will apply to health and education information we already have, as well as any information we receive in the future. We will post a copy of our current notice at our clinic. The notice will contain the effective date on the first page.

COMPLAINTS/GRIEVANCE

If you believe your privacy rights have been violated, you may file a complaint with the U.S. Department of Education **1-800-872-5327**, or with Kidspiration Pediatric Therapy **1-870-424-4021**, contact:

US Dept. of Education
400 Maryland Avenue, SW
Washington, D.C. 20202

Director Leah Coleman
Kidspiration Pediatric Therapy
PO Box 2533
Mtn. Home, AR 72654

All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing below you are confirming that you have been provided a copy of the Notice of Privacy Practices document, and you fully understand all the information listed within this disclosure. You are affirming that this information has been made available, and clear for your understanding.

_____ _____

Client or Legal Guardian Signature: Date

Kidspiration Outpatient Behavioral Health Services

Attendance Policy

Please contact our office at 870-424-4021 if your child is unable to attend his regularly scheduled therapy appointment. Canceled appointment notifications must be made 24 hours in advance or before 7:00am on the day of the scheduled appointment, with an exception of emergencies and unforeseen illnesses. All requests for changes in your child's therapy schedule will need to be discussed with your child's therapist. The following definitions and procedures apply to all attendance topics:

No Shows

Definition: A no show is any missed appointment without a phone call to cancel the appointment(s) a minimum of 24 hours in advance or before 7:00am on the day of the scheduled appointment.

Procedure: No shows are appointments that are not made up and/or rescheduled. They are missed appointments. After three no show appointments, your child will be taken off of the therapy schedule and placed on a waiting list.

Cancellations:

Definition: A cancellation is any appointment canceled by phone or in person 24 hours in advance or before 7:00am on the day of the scheduled appointment. An appointment that is rescheduled does NOT count as a cancellation

Procedure: If your child's attendance rate falls below 75%, there is a possibility that your child's therapy time may be offered to another child on our waiting list. Families who are planning to be absent for greater than 2 weeks will be removed from their treatment schedule, unless previously arranged with your therapist. It is our policy that if you fail to cancel a scheduled appointment within the designated time frame, you will be charged a $25.00 fee for the missed appointment. If your child misses more than one therapy, you will be charged this fee for each hour.

Please note: Therapists are only paid when a child is present. Due to limited scheduling availability, we ask that all patients attend their scheduled treatments. When an appointment is applied to our schedule, that time is reserved to meet your child's needs. We work hard to accommodate each of our patients. Continuous neglect to follow the regulations stated in this policy could lead to termination and/or change of status to your remaining treatments and/or sessions. Thank you in advance for your understanding and cooperation in this matter.

Kidspiration Outpatient Behavioral Health Services

Late Arrivals/Pick-ups

Definition: A late arrival occurs any time the child is 5 minutes or later for their scheduled appointment. If the appointment is scheduled for 3 p.m., and you arrive at 3:05 p.m., you are considered late. It is also necessary that you pick your child up on time, as to not interfere with another child's therapy appointment.

Procedure: If your arrival or availability time is 10 minutes or more after your scheduled appointment time, your therapist may have been reassigned to another child's care and your appointment may be canceled. If you are unsure about whether you can arrive or be available within this time frame, call the clinic and/or therapist to inform them you are running late. Your therapist will determine whether you should reschedule the appointment. A consistent pattern of late arrivals and/or pick-ups will result in a review of your services and possible cancellation of services from Kidspiration. We feel the allotted time for your child's treatment is necessary for adequate rehabilitation of their condition.

*By signing below you are affirming that you have read and understand the attendance policy as it has been presented to you. You will be provided a copy of this policy as well as all others in which you are asked to consent and sign to.

_____ _____

x **Parent/Caregiver/Guardian's Signature** **Date**

OBHS Developmental Questionnaire

ALL THE INFORMATION ON THIS FORM WILL BE CONFIDENTIAL AND USED ONLY FOR THE EVALUATION AND TREATMENT OF YOUR CHILD.

Child's Name _____ Birth Date_____ Sex_____

Mailing Address _____
STREET CITY STATE ZIP CODE

County _____ Home Telephone_____

Child's Physician _____ Location_____

Medicaid Number_____ Social Security Number_____

Person Completing These Forms: _____
Relationship to Client: _____

Therapy Preferences: (Therapist Gender, Location, Time, Type of therapy, ETC.):

_____

_____

_____

FAMILY DATA

School District _____

Father's Name _____ Age_____ Phone_____

Occupation_____

Mother's Name_____ Age_____ Phone_____

Occupation_____

Email Address: _____

Best Contact Name/Number Scheduling: _____

BEHAVIOR

Has your child ever received Behavioral Health Services before? YES_____ NO_____

If yes please provide dates of services, and where services were received:

_____

_____

_____

Have you tried any complementary health approaches (intervention methods: Therapy services, natural remedies, yoga, hypnosis, etc.)? YES _____ NO_____
Please Explain:

_____

_____

_____

_____

Who is the primary disciplinarian? _____
Do parents agree on methods of discipline? YES _____ NO _____

Describe each of your methods:

_____

_____

Is anyone else (ex. School, sitter) having problems with your child's behavior?

YES _____ NO _____

If so, please describe:

_____

_____

How are negative/adverse behaviors handled at home?

_____

_____

_____

Does your child need or have any assistive technology and/or devices? YES _____ NO _____
If so, please describe:

_____

_____

Has your child had any suicidal thoughts/talk/actions you are aware of? If so, please describe what they were, and any actions taken. (Hospitalizations, Acute stays, Residential Treatment - please provide date and location for each and why they were necessary)

_____

_____

Have you and/or your child/family had any psychological and/or social adjustments to any disabilities and/or disorders? Do you need any support for this?

_____
_____
_____

What are some of your child's favorite things?

_____
_____
_____

What do you like best about your child? Is there anything else we should know about your child and/or their behavior?

_____
_____
_____

CHILD'S GROWTH AND DEVELOPMENT

Has your child ever had developmental evaluations (Occupational, Physical, Speech)? _____
If so, when and where were the tests completed? _____

If your child has a diagnosis, please list here: (Also include when the diagnosis was given and by whom)

_____
_____

Has your child been tested for vision? Yes_____ No _____ If yes, when? _____

Where? _____ What were you told? _____

Has child been tested for hearing? Yes _____ No_____ If yes, when?

_____

As compared with other children, describe your child's development._____

_____

Temper Tantrums Yes____ No_____ Describe Tantrums _____

How does your child get along with other children? Adults?

_____

Learning Ability and Intellectual Functioning:

Has your child had any learning or intellectual testing? Yes_____ No_____
If Yes please explain: _____

At what level of learning is your child functioning:
Above Average _____ Average _____ Below Average _____ Uncertain _____

At what level of intellectual ability is your child?
Above Average _____ Average _____ Below Average _____ Uncertain _____

What is your child's literacy level?
Above Average _____ Average _____ Below Average _____ Uncertain _____

How do you feel your child hears?
Well _____ Poorly or not at all _____ Inconsistently _____ Uncertain _____

Does your child have a history of ear infections? _____

Has your child had p.e. tubes placed in his/her ears? _____Date_____

Does your child communicate mostly by: Gestures _____ Crying_____

Sentences _____ Words_____ Phrases_____

When did your child say his/her first real word? _____

Did your child's speech or language development seem to stop for some time? _____

If you answer "yes" to this question, please respond to a and b below.

a. When and why do you think it stopped? _____

b. How did your child communicate with you during this time? _____

How does your child usually let you know what he/she wants_____

If you answer with "pointing" or "gesturing" to this question, please respond to a and b below.

a. Does your child try to talk in combination with pointing? _____

b. Does anyone in the family talk for your child or interpret his/her gestures? If so, who?
_____

Do you think your child's speech is normal for his/her age? _____

IF you answer "no" to this question, please respond to a, b, and c below.

a. How well do you understand your child's speech? _____

b. How well do people outside the family understand your child's speech? _____

c. How does your child react if he/she is not understood by others? _____

FEEDING

For his/her age is your child:

Average weight_____ Underweight_____ Overweight_____

Allergies to any food or drinks? _____

Reactions? _____

Has the child had frequent or severe problems with:

Feeding_____ Chewing_____

Teeth_____ Swallowing_____

What eating problems, diet problems or unusual food habits does the child have?

_____

MEDICAL HISTORY

Has your child ever been seriously ill? YES_____ NO_____

If yes, with what?_____

Has your child ever been hospitalized? _____ When? _____

Why?_____

Has your child been hospitalized for any behavioral needs? _____

If so, please explain: (why, where, when, outcomes)

_____

_____

_____

Has your child had any of the following? (Circle all that apply): x-ray, MRI, CT scan, Other medical tests. Explain: _____

Is your child allergic to any medications? If so, which ones, and explain reactions: _____

_____

_____

_____

Check any of the following which pertain to your child, indication age and complication:

	AGE	COMPLICATIONS
Meningitis and/or Encephalitis		
Convulsions/Seizures		
Fainting Spells		
Headaches and/or Migraines		
Frequent Falls		
Ear Infections		
Diarrhea or constipation		
Head Injury		
Rheumatic Fever		
Diabetes		
Allergies		
Eyes or Visual Problems		

Is your child up to date on their immunizations? Yes _____ No _____

Has your child had any adverse reactions to any immunizations? Yes____ No ____

Please Explain:

_____

_____

****You may be asked to provide a copy of your child's immunization records****

5. FAMILY HISTORY

Has anyone in the family (parent or child) experienced or have a history of neglect, physical or sexual abuse? If yes, please explain:

Family history of any Drug or Alcohol use/misuse (current or previous)?

Does anyone in the family have any diagnosis of any kind (physical, emotional, mental)? If yes, who and what are those diagnosis:

Are these individuals on any medications to manage those diagnoses? Or have they had any hospitalizations for their diagnosis?

Complete the following table for all the mother's pregnancies in chronological order including any miscarriages or stillbirths:

Name	Date of Birth	Birth Weight	Problems at birth	Any physical, emotional, behavioral, or educational problems

***If you haven't already done so please bring in for a copy to be made or provide a copy of your child's:

1. Birth Certificate
2. Insurance Card
3. Any relevant court documents

To complete this intake process you will be asked to come into the office in person for a 1 hour session. Please list any days or times that would best work with your own schedule:

_____

_____

_____

Please list below any other information you believe is relevant for the treatment of your child.

_____

_____

_____

_____

_____

_____

Mental Health Intake and Assessment With Developmental History

I. Identifying Information

Child's Name: _____ DOB: _____ Gender: _____

Gender identification: _____

Gender expression: _____

Sexual orientation: _____

_____

_____

Means of transportation: _____

Does family currently receive any type of social services? ☐ Yes ☐ No

If yes, indentify involved community agencies: _____

_____

Need for social supports: _____

_____

Cultural and/or ethnic needs: _____

_____

Military history of client: _____

_____

Spiritual beliefs of client: _____

_____

Employment history of client: _____

_____

Mental Health Intake and Assessment With Developmental History

Family Information:

Parent 1 Name: _____ (First / Last)

Date of Birth: _____

Lives in home: ☐ Yes ☐ No

Status of parental rights: _____

Current marital status of parents: _____

If divorced, is Parent 1 remarried?: ☐ Yes ☐ No

If yes, name of step-parent: _____

Parent 2 Name: _____ (First / Last)

Date of Birth: _____

Lives in home: ☐ Yes ☐ No

Status of parental rights: _____

Date Divorced, if applicable: _____

If divorced, is Parent 2 remarried?: ☐ Yes ☐ No

If yes, name of step-parent: _____

How often does your child visit the non-residential parent/guardian? _____

DHS caseworker name and phone #, if applicable: _____

Is your child adopted? ☐ Yes ☐ No If yes, what was your child's age when adopted? _____

List all persons living in the child's home:

Name	Age	Relationship to Child

II. Purpose of Evaluation

Behavior/presenting problems and reason for referral, in client's or parent's/guardian's words. Include history, duration, and intensity for presenting problems:

This client's strengths, abilities, and preferences include:

Parent/Guardian strengths and preferences:

Does client have any behavior that you consider unique or different compared to most children you know?

Mental Health Intake and Assessment With Developmental History

III. Family History

General family history:

Primary source of income:

Does the client/family have supportive relationships?

Familiy psychiatric history: (place X in corresponding box)

Mental Health Intake and Assessment With Developmental History

Issues Identified in Biological Family	Mother	Mother's Mother	Mother's Father	Mother's Other	Father	Father's Mother	Father's Father	Father's Other
ADHD								
Alcoholism								
Anxiety								
Attention problems								
Behavior problems								
Bipolar Disorder								
Convicted of a sexual offense								
Convulsions/seizures								
Cptsd								
Depression								
Drug abuse								
Eating disorders								
Hearing or seeing things								
Hyperactivity								
Inpatient hospitalization								
Intellectual disability								
Intense depression								
Involved in criminal behavior								
Language problems								
Learning problems								
Mental illness (depression, bipolar di								
Mood swings								
Motor or vocal tics								
Other								
PTSD								
Speech problems								
Suicide attempt								
Taken medicine for mental illness								

Mental Health Intake and Assessment With Developmental History

IV. Medical History

Parental Pregnancy History:

This child's birth order: _____

The number of mother's other children: _____

Complications and/or medications administered during pregnancy: _____

During this pregnancy, did the mother have illnesses or medical problems? ☐ Yes ☐ No

Was your child prenatally exposed to alcohol, tobacco, or other substances? ☐ Yes ☐ No

If yes, please describe: _____

_____

Birth Information:

Length of pregnancy: _____

Age of Mother at delivery: _____

Length of Labor: _____

Was labor induced? ☐ Yes ☐ No

Labor complications: _____

Birth was: ☐ Vaginal ☐ Cesarean ☐ Breech ☐ Twins or Multiples

Did Mother experience complications? ☐ Yes ☐ No

If yes, please describe: _____

_____

Birth weight: _____

Did the baby need medical assistance in starting to breathe? ☐ Yes ☐ No

Were there other complications with the baby? ☐ Yes ☐ No

How long did the baby stay in the hospital after birth? _____

_____

Did the baby have health problems in the first six months after birth? ☐ Yes ☐ No

If yes, please describe: _____

_____

.ist any serious illnesses, injuries or hospitalizations your child has had (include dates):

_____

_____

_____

ıst any surgeries your child has received (include dates):

_____

_____

as your child had any fevers above 104°? ☐ Yes ☐ No If yes, when? _____

as your child ever had a seizure? ☐ Yes ☐ No If yes, when? _____

your child frequently sick or does he/she have any other ongoing medical needs? ☐ Yes ☐ No

If yes, explain: _____

_____

Mental Health Intake and Assessment With Developmental History

List any current medications your child is taking, how often, dosage, for what condition, and for how long:

List any past medications your child has previously taken, how often, dosage, for what condition, and for how long:

Describe effectiveness of medications:

Child's Growth and Development:

Has your child lost any previously acquired skills? ☐ Yes ☐ No

If yes, what and when:

What is your child's primary language ?

What is the primary language spoken in your home?

Does your child communicate and understand as much and as clearly as his/her same age peers? ☐ Yes ☐ No

If no, explain:

What is your child's current reading level?

What does your child like to do with his/her free time or as extracurricular activities?

What is your child's affective functioning?

What is your child's language functioning?

What is your child's cognitive functioning?

What is your child's motor functioning?

What is your child's sensory functioning?

What is your child's self-care functioning?

What is your child's social functioning?

Mental Health Intake and Assessment With Developmental History

V. School, Education, Legal

Does client have friends? _____

In social activities, does the client most often prefer the company of others (younger, older, own age)?

_____

Legal Assessment:

- ☐ Current juvenile probation
- ☐ Dependent/neglect case
- ☐ FINS petition
- ☐ Foster care placement
- ☐ Other, explain
- ☐ Past juvenile probation
- ☐ Patient has been court ordered to treatment

Describe circumstances of legal issues

_____

_____

_____

_____

School History:

Please list all schools your child has attended, beginning with any daycare or preschool before kindergarten and ending with your hild's current school.

School	Address	Grade or Class Placement(s)	Dates of Attendance

as your child ever repeated a grade? ☐ Yes ☐ No

yes, please specify: _____

_____

as your child ever had an IEP or 504 plan? ☐ Yes ☐ No

yes, when, where, and why? _____

_____

as your child ever been evaluated before, such as by a school, clinic, speech pathologist or other therapist? ☐ Yes ☐ No

yes, when and where? _____

Mental Health Intake and Assessment With Developmental History

Does your child currently receive or has he/she ever received any of the following? (Check all that apply and indicate past, current, or both.)

☐ Applied Behavior Analysis (ABA)	☐ Past	☐ Current
☐ Occupational Therapy	☐ Past	☐ Current
☐ Physical Therapy	☐ Past	☐ Current
☐ Psychotherapy/Counseling	☐ Past	☐ Current
☐ Special Education Services	☐ Past	☐ Current
☐ Speech Therapy	☐ Past	☐ Current

Does your child require assistive technology? ☐ Yes ☐ No

If yes, please explain: _____

VI. Abuse, Treatment, Acuity

Has client experienced or witnessed abuse, neglect, violence, or sexual assult? ☐ Yes ☐ No

If yes, explain _____

Has client experienced any type of trauma? ☐ Yes ☐ No

If yes, explain _____

Current and historical alcohol, tobacco, and drug use of client:

_____

Prior mental health treatment services: ☐ Outpatient ☐ Residential ☐ Acute ☐ Substance Abuse

Historical life areas of functioning impacted and severity of impairment:

Academic functioning	☐ Marked	☐ Moderate	☐ Mild
Age-appropriate self-care	☐ Marked	☐ Moderate	☐ Mild
Environmental stressors	☐ Marked	☐ Moderate	☐ Mild
Family functioning	☐ Marked	☐ Moderate	☐ Mild
Interpersonal relationships	☐ Marked	☐ Moderate	☐ Mild

Describe effectiveness of previous mental health services:

_____

Mental Health Intake and Assessment With Developmental History

Suicidal/homicidal ideation:

Client history:

Family history:

Plan:

VII. Advance Directives

Should the client experience a mental health crisis, who is the appointed health care proxy allowed to make treatment decisions when the legal guardian is unable to do so (release of information will need to be completed for this assigned person if not legal guardian)?

Mental Health Intake and Assessment With Developmental History

VIII. Symptoms/Clinical Indicators

Does the client do any of the following to a degree the guardian would consider inappropriate for someone of his/her age? (If the Client is a member of a minority group in this country or used to reside in a foreign country, be sure to follow up any answers that endorse a symptom as present by the following question: "Yes, but do you consider this to be inappropriate for a child of your ethnic or cultural group?")

Opposition/Defiance

Has the Client shown any oppositional defiant behaviors: ☐ Yes ☐ No

A. During the past 6 months, did the Client show any of the following?

- Is often angry and resentful ☐ Yes ☐ No
- Is often spiteful and vindictive ☐ Yes ☐ No
- Is often touchy or easily annoyed ☐ Yes ☐ No
- Often actively defies adults' request ☐ Yes ☐ No
- Often argues with adults ☐ Yes ☐ No
- Often blames other for his/her mistakes ☐ Yes ☐ No
- Often loses temper ☐ Yes ☐ No

B. Have these behaviors existed for at least 6 months? ☐ Yes ☐ No

C. At what age did these behaviors first cause problems? _____

Notes: _____

_____

Mental Health Intake and Assessment With Developmental History

Aggression/Conduct Issues

Has the client shown any aggressive behaviors? ☐ Yes ☐ No

A. During the past 12 months, did the Client show any of the following?

- Has broken into someone's house or car ☐ Yes ☐ No
- Has caused physical harm to people or animals ☐ Yes ☐ No
- Has deliberately destroyed other's property ☐ Yes ☐ No
- Has had homicidal ideation/threats/plans ☐ Yes ☐ No
- Has run away from home ☐ Yes ☐ No
- Has set fires ☐ Yes ☐ No
- Has stolen something with or without physical confrontation ☐ Yes ☐ No
- Has used a weapon such as a knife, bat, or brick to hurt a person ☐ Yes ☐ No
- Is often truant from school ☐ Yes ☐ No
- Often bullies or threatens others ☐ Yes ☐ No
- Often initiates physical fights ☐ Yes ☐ No
- Often lies to obtain goods or avoid obligations ☐ Yes ☐ No
- Often stays out at night despite parental prohibitions ☐ Yes ☐ No

B. Have three or more of these behaviors occured during the last 12 months? ☐ Yes ☐ No

C. Has at least one of these behaviors occurred during the last 6 months? ☐ Yes ☐ No

D. Did any of these behaviors occur prior to age 10? ☐ Yes ☐ No

Notes: _____

_____

Impulsivity/Distractibility

Does the Client tend to be impulsive or easily distracted? ☐ Yes ☐ No

A. During the past 6 months, did the Client show any of the following?

- Often fails to give close attention to details, makes careless mistakes ☐ Yes ☐ No
- Often has difficulty sustaining attention ☐ Yes ☐ No
- Often doesn't follow through on instructions or fails to finish school work or chores ☐ Yes ☐ No
- Often has difficulty organizing tasks or activities ☐ Yes ☐ No
- Often avoids to engage in tasks that require sustained mental effort ☐ Yes ☐ No
- Often loses things ☐ Yes ☐ No
- Is often easily distracted ☐ Yes ☐ No
- Is often forgetful in daily activities ☐ Yes ☐ No
- Often fidgets with hand or feet or squirms in seat ☐ Yes ☐ No
- Often leaves seat in the classroom or other situation where remaining seated is required ☐ Yes ☐ No

Mental Health Intake and Assessment With Developmental History

Often runs about or climbs excessively	☐ Yes	☐ No
Often has difficulty playing quietly	☐ Yes	☐ No
Is often "on the go"	☐ Yes	☐ No
Often talks excessively	☐ Yes	☐ No
Often blurts out answers before questions have been completed	☐ Yes	☐ No
Often has difficulty awaiting turn	☐ Yes	☐ No
Often interrupts others	☐ Yes	☐ No
Often ehibits risk taking behaviors	☐ Yes	☐ No

B. Have these behaviors existed for at least 6 months? ☐ Yes ☐ No

C. At what age did they first cause problems? _____

Notes: _____

_____

Specific Phobia

A. Does the Client show a marked or persistent fear that is excessive or unreasonable in response to the presence or anticipation of a specific object or situation? ☐ Yes ☐ No

(E.g. certain animals, thunderstorms, flying, or shots) If yes, explain.

_____

_____

Social Phobia

A. Does the Client show a marked or persistent fear in response to the presence or anticipation of a social performance situation? If yes, explain. ☐ Yes ☐ No

_____

_____

Separation Anxiety Disorder

A. Does the Client show recurrent and excessive distress when separating from home or from a parent? ☐ Yes ☐ No

B. Have these fears persisted for at least four weeks? ☐ Yes ☐ No

If yes to either question, explain.

_____

_____

Mental Health Intake and Assessment With Developmental History

Generalized Anxiety Disorder

A. Does the Client show excessive anxiety and worry about a number of events or activities? If yes, explain. ☐ Yes ☐ No

B. Has this anxiety occured on more days than not for the last 6 months? ☐ Yes ☐ No

_____

_____

Panic Attacks

A. Has the Client exhibited symptoms of a panic attack. If yes, explain. ☐ Yes ☐ No

_____

_____

Depression

Has the Client shown any depressive symptoms? ☐ Yes ☐ No

A. Has the Client exhibited any of the following:

- Depressed or irritable mood most of the day nearly every day for at least two weeks ☐ Yes ☐ No
- Markedly diminished interest or pleasure in almost all activities most of the day, nearly every day for at least 2 weeks ☐ Yes ☐ No
- Significant changes in weight or appetite ☐ Yes ☐ No
- Difficulty sleeping ☐ Yes ☐ No
- Agitated or excessive movement nearly every day ☐ Yes ☐ No
- Fatigue or loss of energy nearly every day ☐ Yes ☐ No
- Feeling of worthlessness ☐ Yes ☐ No
- Feelings of hopelessness ☐ Yes ☐ No
- Diminished ability to think or concentrate, or indecisiveness ☐ Yes ☐ No
- Recurrent thoughts of death ☐ Yes ☐ No
- Recurrent thoughts of suicide without a specific plan ☐ Yes ☐ No
- Suicide attempt or a specific plan ☐ Yes ☐ No
- Thoughts of self-harm ☐ Yes ☐ No
- Self-harm behaviors ☐ Yes ☐ No

B. Have these behaviors occurred daily for at least 2 weeks? ☐ Yes ☐ No

C. Have these behaviors persisted for more than 6 months? ☐ Yes ☐ No

Notes: _____

_____

Mental Health Intake and Assessment With Developmental History

Other Mental or Developmental Disorders

A. Does the Client have anything which he/she seems obsessed with or cannot get off his/her mind? If yes, explain. ☐ Yes ☐ No

B. Does the Client have unusual behavior he/she must perform such as dressing, bathing, counting? If yes, explain. ☐ Yes ☐ No

C. Does the Client demonstrate any nervous, tics, repetitive behaviors, repetitive sounds or noises? If yes, explain. ☐ Yes ☐ No

D. Has the Client ever made comments or acted in a way that he/she seemed to see things, hear things or feel things that did not exist? If yes, explain. ☐ Yes ☐ No

E. Has the Client demonstrated on elevated, expansive, or irritable mood for at least one week? If yes, explain. ☐ Yes ☐ No

F. Has the Client ever exhibited hypersexual or inappropriate sexual behaviors? If yes, explain. ☐ Yes ☐ No

Mental Health Intake and Assessment With Developmental History

Social Communication/Interaction

Does the Client exhibit persistent deficits in social communication and social interaction? ☐ Yes ☐ No

A. Has the Client exhibited any of the following?

Does the client struggle with social-emotional reciprocity? ☐ Yes ☐ No

Does the client have difficulties with nonverbal communicative behaviors used for social interaction? ☐ Yes ☐ No

Does the client have problems developing, maintaining, and understanding relationships? ☐ Yes ☐ No

Does the client exhibit restricted, repetitive patterns of behavior or interests? ☐ Yes ☐ No

Does the client exhibit stereotyped or repetitive motor movements, use of objects, or speeh? ☐ Yes ☐ No

Does the client insist on sameness, show inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior? ☐ Yes ☐ No

Does the client have any highly restricted, fixated interests that are abnormal in intensity or focus? ☐ Yes ☐ No

Does the client have any hyper- or hyperactivity to sensory input or unusual interest in sensory aspects of the environment? ☐ Yes ☐ No

B. Were these symptoms present in the early development period? ☐ Yes ☐ No

C. Has the Client been diagnosed with an intellectual disability? ☐ Yes ☐ No

Notes: _____

_____

X. Stressors and Life areas

Psychosocial Stressors/Events (check all that apply):

Change in living situation ☐ Yes ☐ No

Custody/placement issues ☐ Yes ☐ No

Family health issues ☐ Yes ☐ No

Financial difficulties ☐ Yes ☐ No

Legal Issues ☐ Yes ☐ No

Physical/sexual/emotional abuse ☐ Yes ☐ No

Recent loss ☐ Yes ☐ No

School/work problems ☐ Yes ☐ No

Separation/divorce ☐ Yes ☐ No

Notes: _____

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