Children's National Health System

Psychiatry & Behavioral Medicine New Patient Intake Packet

Children's National Health System

Dear Parent or Guardian,

Thank you for choosing Children's National Medical Center for your child's care. Per your request, I am sending you the new patient Intake Packet. We have a wide variety of general and specialized psychiatric services available in our department. We are an academically driven program that incorporates trainees at every level of clinical services.

We have a detailed intake process that is designed to improve efficiency and provide best service possible. In order to set up an appointment and receive an appropriate evaluation for your child, we ask that you carefully fill out all of the enclosed forms as completely as possible and return them via email, fax or US mail to the address provided below. Once we receive your packet, our team will review the information for the appropriate clinician and appointment. You will be contacted by one of our team members as soon as an appointment date becomes available.

Please include when returning:

1. A copy of your child's most recent physical exam and immunization record
2. A copy of front and back of your child's insurance card

Please note:

- We see children from ages 2 to 17 ½ years old.
- For all Forensic and court ordered cases please pursue appropriate community resources.
- Currently the Psychiatry and Behavioral Medicine Division Out-Patient Clinic is out of network with the following insurances and any appointment scheduled will be self-pay: BCBS HMO, CIGNA and Straight VA Medicaid.

Please be advised the appointments that we schedule are for our main campus in Washington, D.C.

Methods for returning your packet are as follows:

Mail: Children's National Medical Center
Division of Behavioral Science
111 Michigan Avenue NW, West Wing Floor P1
Washington, D.C. 20010
Fax: 202-476-5537
Email: enoel@childrensnational.org
Main Number: 202-476-2118
Intake/New Patient: 202-476-4733

Thank you for choosing Children's National Medical Center for your child's care.

Children's National Health System

INFORMATION ALL PARENTS SHOULD KNOW ABOUT MENTAL HEALTH INSURANCE COVERAGE

Children's National Medical Center Outpatient Psychiatry provides in network services for a wide variety of insurance providers. We also provide documentation of billing and services if you prefer out of network coverage.

Please note that mental health coverage is frequently very different from medical coverage. Also, benefits allowed by your insurance provider are frequently subject to change beyond our control. We strongly encourage you to contact your insurance provider or benefits administrator to verify the specific mental health services allowed by your insurance plan.

- **Verification of mental health benefits and preauthorization for services**: As a courtesy to you, we obtain information regarding your mental health benefits and preauthorization before you r first visit. You will be provided with the information we are given by your health plan and we encourage you to refer to your policy manual or call your plan to confirm the information provided to us.

- **Co-payments**: Costs are often a percentage of the charges incurred instead of a fixed dollar amount. Information about co-payments for mental health services is rarely listed on the insurance card and is obtained by calling the plan.

- **Deductibles**: Mental health services are often separate and in addition to the medical deductible outlined by your insurance plan. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

- **Referrals**: If your child is covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your child's primary care physician prior to your visit. Please note that a written referral is a requirement of the insurance company and that we must adhere to the plan's administrative requirements in order to receive payment on your behalf.

- **Limits**: Frequently, mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

- **Testing**: Neuropsychological, psychological, and developmental testing benefits are always verified by our staff. Most insurance companies limit the number of testing hours covered. If your child requires testing beyond the number of hours authorized, you have the option of paying for the additional hours required for testing.

Children's National Health System

Additional Services

The services listed below are not part of the services offered in the Psychiatry and Behavioral Medicine Division. Please call that specific department for required paper-work and scheduling:

For, Neuropsychiatry, Dyslexia and Learning Disability Testing please call: 301-765-5443.

For, Autism, PPD & Asperger please call: 301-765-5432.

For, Concussion please call: 202-476-2429.

For, Psycho- Educational/Educational Testing please call: 571-405-5912/5797.

For, Hearing & Speech Evaluation please call: 202-476-5600.

For, Sexual Abuse or Misconduct please call: 202-476-4100/5267

For, Developmental Clinic please call: 202-476-6047

For additional resources we have included this link:

http://dchealthcheck.net/resources/healthcheck/mental-health-guide.html

Children's National Health System

Demographic Sheet

PATIENT'S NAME:	PATIENT DATE OF BIRTH:
ADDRESS:	
SEX:	CELL NUMBER:
HOME TELEPHONE: RACE:	EMAIL ADDRESS:

REASON FOR SEEKING MENTAL HEALTH SERVICES (check all that apply)

☐ Behavior Problems
☐ Attention Deficit/Hyperactivity Disorder
☐ Depression
☐ Anxiety
☐ Autism
☐ Psychological/Educational Testing
☐ Developmental Evaluation
☐ Custody/Court/Legal
☐ Suicidal Ideation
☐ Other

WHO REFERRED YOU TO CNMC DEPTMENT OF PSYCHIATRY/PSYCHOLOGY?

☐ CNMC Pediatrician _____
☐ Non-CNMC Pediatrician _____
☐ Specialist (indicate specialty) _____
☐ School
☐ Emergency Department
☐ Other (specify)
☐ General Hospital Discharge
☐ Psychiatric Hospital Discharge
☐ Social Worker/Counselor
☐ Psychiatrist
☐ Self-referred

INSURANCE INFORMATION (no information will be treated as self-pay)

Primary Insurance Company:	Secondary Insurance Company:
Policy/Identification Number:	Policy/Identification Number:
Group Name/Number:	group Name/Number:
Insurance Telephone Number:	Insurance Telephone Number:
Subscriber's/Policy Holder's Name:	Subscriber's/Policy Holder's Name:

FINANCIALLY RESPONSIBLE PARTIES (GUARANTORS)

Primary Guarantor's Name:	Secondary Guarantor's Name:
Relationship to Patient:	Relationship to Patient:
Address (if different from patient):	Address (if different from patient):
Employer:	Employer:
Address:	Address:
Home# Cell#	Home# Cell#
Work# Email:	Work# Email:
Social Security Number:	Social Security Number:
DOB: Marital Status:	DOB: Marital Status:
Name of School the Child Attends and Address:	

Child's History Questionnaire

Child's Full Name: _____

Child's Date of Birth: _____

Name of the person completing this form: _____

Today's date: _____

Contact Information:

Parent's full name: _____
Address: _____

_____

Phone: _____
Date of Birth/Age: _____
Profession and/or
work activity _____

Parent's full name: _____
Address: _____

_____

Phone: _____
Date of Birth/Age: _____
Profession and/or
work activity _____

Other primary caregiver (Guardian/Significant Other/Other)
Caregiver's full
name: _____
Age: _____
Profession and/or
work activity _____

Emergency Contact
Name : _____
Address: _____

_____

Phone: _____

What are the main concerns that you have about your child? **(Required)**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What would you like to accomplish at this first visit? **(Required)**

_____
_____
_____
_____
_____

What is your expectation after your initial appointment? **(Required)**

_____
_____

Child's Race and Religion:

Race/Ethnicity:		**Religion:**	
American Indian/ Alaska Native	_____	Protestant	_____
Asian: Indian/Pakistani	_____	Muslim	_____
Asian: Chinese	_____	Jewish	_____
Asian: Other-specify	_____	Hindu	_____
Hispanic or Latino	_____	Catholic	_____
Black/African American	_____	Buddhist	_____
White/Caucasian	_____	Other: Specify	_____
Other: Specify	_____	None	_____

Is the child adopted? Yes_____ No _____

Are there other children in the family? If yes please list

Name	Gender	Date of Birth	Age	Relation to child

Other persons living in the home (significant other, friend, grandparents, foster child, etc)

Name	Gender	Date of Birth	Age	Relation to child

Languages spoken in the home_____

List any Agencies or professionals currently providing services to your child and family.

Agencies or professional	Age of child when services begun

Pregnancy History

During pregnancy with this child did the mother experience any of the following?

Medical Problems No ____ Yes ____ If yes, how long _____

Special diet No ____ Yes ____ If yes, how long _____

Medications No ____ Yes ____ If yes, how long _____

Length of pregnancy Full-term (38-42 weeks) No ____ Yes ____

Number of weeks at birth _____

Any accidents/injuries No ____ Yes ____ If yes, describe_____

Birth History

Age of mother at birth of child _____

Complications for mother during delivery No _____ Yes _____

If yes, list _____

_____

_____

Child's birth weight _____

Did the child need any of the following?

Was Oxygen Needed No _____ Yes _____ if yes, why? _____

Special care No _____ Yes _____ if yes, why? _____

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

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

<u>Describe your child in the first 6 months.</u>

Easy baby No _____ Yes _____

Enjoys people No _____ Yes _____

Irritable No _____ Yes _____

Difficult to sooth No _____ Yes _____

Sleep/wake cycle poorly regulated No _____ Yes _____
Unusually quiet No _____ Yes _____
Unusually sick No _____ Yes _____
Feeding difficulties No _____ Yes _____
Strong reaction to light/sound/touch No _____ Yes _____
Colic No _____ Yes _____

Family History

Please list any medical or psychiatric illness in your family

_____
_____
_____

Child's Early Development (specify age)

Sat without support _____
Crawled _____
Walked without support _____
Used single words _____
(Other than mama or papa)
Used 2-3 word sentences _____
First began to sleep through the night _____
Daytime wetting stopped _____
Bed-wetting stopped _____
Bowel control _____

Child's Medical History

Health Care Providers:
Child's primary care physician: _____
Address: _____
_____
Phone: _____

Date of last complete physical examination: _____

Does your child have any allergies (environmental, food, medication)? No ____ Yes ____
If yes, please list:

_____
_____
_____

Does your child take any medications? No ____ Yes ____

(Include vitamins, over the counter drugs, and herbal medications)

Name	Dosage	Frequency	Date began

Has your child ever been hospitalized for any reason? No ____ Yes ____

If yes, describe

Reason	Date	Place	Length of stay

Does your child have a current or past history of? Any of the following:

	No	Current	Past	List
Head injury				
Broken bones				
Surgeries				
Birth defects				
Poisoning (e.g.: lead)				
Heart problems				
Kidney problems				
Liver disease				
Lung disease				
Blood disease				
Cancer				
Seizure				
Other neurological problems (e.g.: headache)				
Genetic disorder				
Hormonal problems (e.g.: diabetes, thyroid)				
Skin problems				
Lyme disease				
Impaired Sight				
Impaired Hearing				
Speech Difficulty				
Sleeping Difficulty				
Eating Disorder				
Sleep Apnea				
Severe vomiting				
Choking events				
Other problems				

Childhood diseases (child's age in years)

Chicken pox	No ____	Yes ____	Age _____
German measles/Rubella	No ____	Yes ____	Age _____
Measles	No ____	Yes ____	Age _____
Scarlet Fever	No ____	Yes ____	Age _____
Whooping cough	No ____	Yes ____	Age _____
Strep throat	No ____	Yes ____	Age _____

Social Development

Does your child make friends easily: No _____ Yes _____

Does your child have any difficulties interacting with other children?

No _____ Yes _____

Does your child have any difficulties interacting with adults?

No _____ Yes _____

Does your child have a "best friend?" No _____ Yes ____

Preschool/School History

Is your child attending preschool/school? No _____ Yes _____

If yes, name of school _____

Child's current school grade _____

Does your child attend any special classes or receive any special education services?

No _____ Yes _____ if yes, please name _____

Has your child ever repeated a grade in school or been "held-back" for any reason?

No _____ Yes _____ if yes, explain _____

Does your child have any learning or behavioral problems in school?

No _____ Yes _____ if yes, explain _____

_____

_____

_____

Sleep Habits

What time does your child generally go to bed? _____ pm/am

What time does your child generally wake up? _____ pm/am

On average, how many hours does your child sleep per night? _____hours

Does your child snore or seem to gasp for air during the night? No _____ Yes _____

Stressors

Is your child facing significant stressors at this time? No _____ Yes _____

If yes, please describe

_____

_____

_____

_____
_____

Is your family facing any significant stressors just now?

_____
_____
_____
_____
_____

Is there anything else you would like us to know that would assist us in understanding your child?

_____
_____
_____
_____
_____
_____
_____

The SNAP-IV Teacher and Parent Rating Scale

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Name: _____ _____ Gender: _____ Age: _____

Completed by: _____Date:_____Rx_____

For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
TOTAL				
INATTENTION AVERAGE SCORE (TOTAL/9) (2.56T; 1.78P)				
11. Often fidgets with hands or feet or squirms in seat				
12. Often leaves seat in classroom or in other situations in which remaining seated is expected				
13. Often runs about or climbs excessively in situations in which it is inappropriate				
14. Often has difficulty playing or engaging in leisure activities quietly				
15. Often is “on the go” or often acts as if “driven by a motor”				
16. Often talks excessively				
17. Often blurts out answers before questions have been completed				
18. Often has difficulty awaiting turn				
19. Often interrupts or intrudes on others (e.g., butts into conversations/games)				
TOTAL				
HYPERACTIVE/IMPULSIVE AVERAGE SCORE (TOTAL/9) (1.78T; 1.44P)				
For each item, check the column which best describes this child:	Not At	Just A	Quite	Very Much

	All 0	Little 1	A Bit 2	3
21. Often loses temper				
22. Often argues with adults				
23. Often actively defies or refuses adult requests or rules				
24. Often deliberately does things that annoy other people				
25. Often blames others for his or her mistakes or misbehavior				
26. Often touchy or easily annoyed by others				
27. Often is angry and resentful				
28. Often is spiteful or vindictive				
TOTAL				
ODD AVERAGE SCORE (TOTAL/8) (1.38T; 1.88P)				
29. Has difficulty getting started on classroom assignments				
30. Has difficulty staying on task for an entire classroom period				
31. Has problems in completion of work on classroom assignments				
32. Has problems in accuracy or neatness of written work in the classroom				
33. Has difficulty attending to a group classroom activity or discussion				
34. Has difficulty making transitions to the next topic or classroom period				
TOTAL				
ACADEMIC AVERAGE SCORE (TOTAL/6)				
35. Has problems in interactions with peers in the classroom				
36. Has problems in interactions with staff (teacher or aide)				
37. Has difficulty remaining quiet according to classroom rules				
38. Has difficulty staying seated according to classroom rules				
TOTAL				
DEPORTMENT AVERAGE SCORE (TOTAL/4)				
ADHD AVG SCORES (IN; H-I)				
ADHD-C AVERAGE SCORE (TOTAL/2) (2.00T; 1.67P)				

Children's National Health System

Department of Behavioral Medicine

Authorization of Release of Information

I, the parent/guardian of _____ hereby consent to and to authorize Children's National Medical Center Department of Behavioral Medicine to
(_) release to (_) release from:
_____
_____
_____

The following information:

___ Psychiatric Records
___ Psychological/ Educational Assessments
___ Psychosocial Assessment
___ ARD Materials
___ History of Allergies
___ Last Report Card, Consumer's Forms
___ Medication/ Laboratory Data EKG
___ Last Physical Examination
___ Immunization Records
___ Other _____

I also understand that my insurer requires information regarding my child's treatment; I agree to have this information released as requested. The District of Columbia Mental Health Information Act requires the following notice: The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1988, Disclosures may only be made pursuant to valid authorization by the client or as provided in Title III or IV or that Act. The Act provides for civil damages and criminal penalties for violations.

_____ _____
Signature of Patient Date of Birth

_____ - _____ - _____ _____
Social Security Number Expiration Date (If Not One Year of Signature Date)

_____ _____
Signature of Parent/ Legal Guardian Date

_____ _____
Witness Date

Department of Behavioral Medicine
111 Michigan Ave NW, West Wing Floor P1
Washington, DC 20010
(202)476-2118

Children's National Health System

Label

DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES

CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

I give consent for my child, _____, to receive outpatient mental health services and at the CNMC Department of Psychiatry and Behavioral Sciences. Outpatient mental health services include any or a combination of the following: evaluation, individual therapy, group therapy, family therapy, psychological or neuropsychological testing, and medications. I consent to allow my child to participate in program activities directly associated with his/her mental health evaluation and treatment, and as appropriate, to involve my child's family members. I authorize Children's National Medical Center to review my child's medical record for teaching purposes. I understand that all the personal information that I provide about my child and our family will remain confidential and any published data will keep the identity of my child and family confidential. I declare that I am this child's legal guardian.

DISCONTINUATION OF TREATMENT POLICY

NO SHOW POLICY: All new and follow up appointments must be cancelled at least 24 hours prior to the appointment time. Cancellation or reschedule requests on the day of the appointment are considered NO SHOW appointments.

Please be aware that the Department of Psychiatry and Behavioral Sciences may discontinue your child's treatment for any of the following reasons:

- Achievement of treatment goals.
- Failure to appear for two or more appointments within a two-month period, without at least a 24-hour notification.
- Being consistently late for appointments or consistently cancelling appointments.
- Not participating in treatment for a period of 90 consecutive days.

I hereby certify that I have been informed of my rights and responsibilities and of the grievance procedures as a client of CNMC Department of Psychiatry and Behavioral Sciences.

_____
Print Parent or Guardian Name

_____ _____
Parent or Guardian Signature Date

_____ _____
Staff/Witness Signature Date

Children's National Health System

As a patient in the Department of Psychiatry, you and your child have a right:

- To be treated with dignity and respect.
- To receive the most appropriate treatment regardless of age, gender, race religion, sexual orientation, national origin, or method of payment.
- To know what fees will be charged for your child's treatment in advance.
- To know the name and professional status of those persons providing your child's treatment.
- To participate in the development of a comprehensive Individual Treatment Plan and to receive treatment according to this treatment Plan.
- To be informed of any possible side effects of prescribed medication.
- To privacy and confidentiality concerning your child's treatment and his/her medical record. Information from your child's record will be released only with your written permission. However, all Department staff involved with your child's treatment will share information with one another.
- To be free from physical, mental and sexual abuse or harassment.
- To be free from intrusive research.
- To have your concerns addressed in a timely manner, generally at the point of service, without fear of retaliation.
- To file a confidential verbal or written complaint regarding your child's treatment. An impartial investigation will be initiated within 24 hours of receipt of complaint. Complaints may be filed up to 30 days from date of discharge. All complaints to CNMC will be resolved within 30 days of the date of complaint. To file a complaint, you may:
    1. Start informally by contacting the Team Leader or any staff member in the clinic location where your child is receiving treatment. If your claim is not resolved in five (5) business days, you may contact;
    2. The Department of Psychiatry's Program Manager at (202) 476-3935 and/or the Medical Director at (202) 476-3932. If your complaint remains unresolved after (10) business days, you may contact;
    3. The CNMC Family Services Department at (202) 476-3070. If your complaint is not resolved after five (5) business days, you may;

Contact any of the following health advocacy groups to obtain assistance in resolving any complaints about the services you received at Children's Hospital Department of Psychiatry: 1) On Our Own at 1-800-704-0252; 2) Maryland Attorney General's Office, Health Advocacy Office at (410) 528-1840.

If your child is covered under Maryland Medicaid and your concerns remain unresolved after notifying the Children's Hospital staff, you have the right to file a complaint or grievance with the Maryland Public Mental Health System (PMHS).

1. Maryland Health Partners at 1-800-888-1965.
2. The Core Service Agency in the consumer's county of residence. (Please contact our staff for assistance in obtaining the telephone number).
3. Maryland Mental Hygiene Administration at (410) 767-6611.

As a patient in the Department of Psychiatry, you have a responsibility:

- To keep your appointment or notify the Department of any changes as early as possible.
- To collaborate in the development of your child's Individualized Treatment Plan.
- To work toward the achievement of your treatment goals.
- To be honest with staff by sharing anything that might impact upon your child's treatment.
- To obtain all necessary treatment referrals from your child's primary care physician and from your health plan.
- To pay your fees on time/or discuss with staff any related financial difficulties.
- To promptly provide information regarding the loss or gain of third party benefits or income.
- To let staff know if you are dissatisfied in any way with your child's treatment.
- To inform staff of your desire to terminate treatment, especially if you have not achieved your treatment goals.

_____ _____

Parent/legal guardian/Patient Signature Date