Psychiatry & Behavioral Medicine
New Patient Intake Packet
Dear Parent or Guardian,

Thank you for choosing Children’s National Hospital 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 17½ 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 Hospital
  Psychiatry and Behavioral Medicine
  Takoma Theater Outpatient Center
  6833 4th Street, NW
  Washington, D.C. 20012
- **Fax**: 202-715-5428
- **Email**: psynewappointmentreq@childrensnational.org
- Main Number: 202-729-3300
- Intake/New Patient: 202-729-3300 option #2

Division of Psychiatry and Behavioral Medicine, Washington DC
Thank you for choosing Children’s National for your child’s care.

INFORMATION ALL PARENTS SHOULD KNOW ABOUT MENTAL HEALTH INSURANCE COVERAGE

Children’s National 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 your 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.

**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 paperwork and scheduling:

For, **Medical Records** please call: **202-476-5267**

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

For, **Autism** Spectrum Disorder Comprehensive Assessments 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, Abuse (Neglect, Physical and/or Sexual Abuse) please call: **202-476-4100/5267**

**For additional resources we have included this link:**

Welcome to Children's National. We are delighted your family has chosen to receive care here and we look forward to working with you and your family. In the Division of Psychiatry and Behavioral Sciences we provide a vast array of services. Currently, the Division of Psychiatry does not provide forensic services to children, adolescents, and their families. Disputes between parents regarding custody and visitation matters are considered forensic matters and are beyond the scope of services that we provide. However, in families in which divorce has already occurred and where care is not being sought as part of a dispute over custody or visitation we will ask for a copy of the legal custody rights of the parents in order to delineate which parent has the ability to legally consent to a psychiatric evaluation and ongoing treatment. If both parents share legal custody, both parents will be asked to participate in the psychiatric evaluation and ongoing treatment of the child. When possible, the best care of the child is optimally provided when both parents are able to participate in their child’s care.
### Demographic Sheet

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**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 CHILDREN’S DEPARTMENT OF PSYCHIATRY/PSYCHOLOGY?**

- [ ] Children’s Pediatrician ________________________
- [ ] Non-Children’s 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)

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**FINANCIAL RESPONSIBLE PARTIES (GUARANTORS)**

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**Name of School the Child Attends and Address:**

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Division of Psychiatry and Behavioral Medicine, Washington DC
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 ____________________________________

Division of Psychiatry and Behavioral Medicine, Washington DC
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: 
American Indian/Alaska Native
Asian: Indian/Pakistani
Asian: Chinese
Asian: Other-specify
Hispanic or Latino
Black/African American
White/Caucasian
Other: Specify

Religion:
Protestant
Muslim
Jewish
Hindu
Catholic
Buddhist
Other:
Specify
None

Is the child adopted? Yes______ No ______

Department of Behavioral Medicine

Authorization of Release of Information

I, the parent/guardian of _______________________________ hereby consent to and to authorize Children’s National Department of Behavioral Medicine to release to release from:

___________________________________________________________________________________
___________________________________________________________________________________

The following information:
___ Psychiatric Records ___ Last Report Card, Consumer’s Forms
___ Psychological/ Educational Assessments ___ Medication/ Laboratory Data EKG
___ Psychosocial Assessment ___ Last Physical Examination
___ ARD Materials ___ Immunization Records
___ History of Allergies ___ 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.
CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

I give consent for my child, ______________________________, to receive outpatient mental health services and at the Children’s National 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 Hospital 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.

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
Takoma Theater Outpatient Center
6833 4th Street, NW
Washington, DC 20012
(202)729-3300

DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES

Division of Psychiatry and Behavioral Medicine, Washington DC
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 Children’s National Department of Psychiatry and Behavioral Sciences.

___________________________________
Print Parent or Guardian Name

___________________________________                                    __________________
Parent or Guardian Signature                                    Date

___________________________________                                    __________________
Staff/Witness Signature                                    Date

Division of Psychiatry and Behavioral Medicine, Washington DC
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 Children’s National 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 Children’s National 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