



# 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 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 Hospital  
Psychiatry and Behavioral Medicine  
Takoma Theater Outpatient Center  
6833 4<sup>th</sup> Street, NW  
Washington, D.C. 20012

**Fax:** 202-715-5428

**Email:** [psynewappointmentreq@childrensnational.org](mailto: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 paper-work 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:**

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



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

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)

- |   |   |
|---|---|
| <input type="checkbox"/> Behavior Problems<br><input type="checkbox"/> Attention Deficit/Hyperactivity Disorder<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Autism | <input type="checkbox"/> Psychological/Educational Testing<br><input type="checkbox"/> Developmental Evaluation<br><input type="checkbox"/> Custody/Court/Legal<br><input type="checkbox"/> Suicidal Ideation<br><input type="checkbox"/> Other |
|---|---|

**WHO REFERRED YOU TO CHILDREN'S DEPARTMENT OF PSYCHIATRY/PSYCHOLOGY?**

- |   |   |
|---|---|
| <input type="checkbox"/> Children's Pediatrician _____<br><input type="checkbox"/> Non- Children's Pediatrician _____<br><input type="checkbox"/> Specialist (indicate specialty) _____<br><input type="checkbox"/> School<br><input type="checkbox"/> Emergency Department<br><input type="checkbox"/> Other (specify) | <input type="checkbox"/> General Hospital Discharge<br><input type="checkbox"/> Psychiatric Hospital Discharge<br><input type="checkbox"/> Social Worker/Counselor<br><input type="checkbox"/> Psychiatrist<br><input type="checkbox"/> 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:
<b>Name of School the Child Attends and Address:</b>	



## 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:

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Age:

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Profession

and/or work

activity

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**Emergency Contact**

Name :

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Address:

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Phone:

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

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

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

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**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
- \_\_\_ 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.



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Signature of Patient

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Date of Birth

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Social Security Number

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Expiration Date (If Not One Year of Signature Date)

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Signature of Parent/ Legal Guardian

-----  
Date

-----  
Witness

-----  
Date

Department of Behavioral Medicine  
Takoma Theater Outpatient Center  
6833 4<sup>th</sup> Street, NW  
Washington, DC 20012  
(202)729-3300

Label
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**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 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.



**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.***

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Print Parent or Guardian Name

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Parent or Guardian Signature

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Date

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Staff/Witness Signature

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Date



### **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.



**Children's National.**

**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.

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Parent/legal guardian/Patient Signature

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Date