Origins Health & Wellness, LLC
Health by choice, not by chance.

New Child Client Intake

Date: _____

Child's Name: _____ Home Address: _____

Date of Birth: _____ Age: _____ City/State/Zip: _____

Gender: Male Female Other: _____ Ethnicity: Hispanic Not Hispanic

Race: (circle all that apply) African-American Asian-American Native American White/Caucasian Other:

FAMILY INFORMATION

Mother's Name: _____ Father's Name: _____

Biological? Adoptive? Step? Foster/Guardian? Biological? Adoptive? Step? Foster/Guardian?

Age: ___ Occupation: _____ Age: ____ Occupation: _____

Employer: _____ Employer: _____

Work Schedule: _____ Work Schedule: _____

Phone # to be reached: _____ Phone # to be reached: _____

Email: _____ Email: _____

Biological Parents: Married ____ Divorced ____ Separated ____ Never Married ____

Date: Date: Date:

Who has Physical Custody: _____ NA

Who has Legal Custody: Joint Custody/Both parents One parent _____ Ward of the State

If ward of the State: Caseworker's Name _____ Phone #: _____

Child/client resides with: Mother Father

Biological Adoptive Foster Step Other Biological Adoptive Foster Step Other

Other Members of the Household (for example, siblings, step-siblings, foster children):

Name	Age	Sex	Relationship to child/client
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____
_____	___	___	_____

Emergency Contact:

Name: _____ Relationship to child/client: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Other Regularly Involved Adults (for example, grandparents, non-custodial parents/step-parents):

Name	How Often	Relationship to child/client
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any problems/stressors in the family in the last year? (for example, death in the family, move, parental/marital conflict, financial stressors, accidents/traumatic events) _____

_____

SCHOOL INFORMATION

Child attends daycare? NO YES (name of daycare/child care provider) _____

Child attends school? NO YES grade _____ (If summer, what grade will child be entering in the fall?)

School name: _____ Teacher's Name: _____

Child current grades are? _____ Grades last semester were? _____

Has the child/client ever been suspended or expelled? NO YES When?_____

Has the child/client ever been retained in a grade? NO YES When? _____

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems? NO YES When? _____

Has the child/client ever had an IEP, 504 Plan, or other Special Education Services? NO YES

(E.g., learning disability, behavioral/emotional disorder class, speech/language services, resource room)

DEVELOPMENTAL INFORMATION

Were there any problems with pregnancy or delivery? NO YES

Were there any concerns with drug/alcohol use or cigarette use during pregnancy? NO YES

Was the child born prior to 36-40 weeks gestation? NO YES If yes, list gestation at birth: _____

What is your impression of your child's health/development in their first year of life? GOOD FAIR POOR

Note the month in which your child achieve the following activities:

Sat alone ____ Crawled ____ Walked ____ Fed Self _____ Spoke Words _____ Toilet Trained _____

(Normal development in months: Sit 6-8, Crawl 9, Walk 12-18, Fed 10-12, Speak 10, Toilet 24-36)

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MEDICAL INFORMATION

Any problems with the child/client's vision? NORMAL ABNORMAL CORRECTED

Any problems with the child/client's hearing? NORMAL ABNORMAL CORRECTED

Any problems with the child/client's speech? NORMAL ABNORMAL CORRECTED

Circle all conditions which this child/client currently has:

ALLERGIES ASTHMA CANCER DIABETES GENETIC CONDITION SEIZURES

Other medical conditions/health concerns: _____

Specialists/health care providers that are currently involved with the child/client's care (e.g., allergist, speech therapist, etc.) _____

Any hospitalizations? NO YES If yes, please add dates and explain _____

Any surgeries? No YES If yes, please add dates and explain _____

Any history of head trauma/injury or loss of consciousness? NO YES _____

Current Medications

Medication Name	Dosage	Purpose	Date Started	Prescribed By

Any over the counter medications routinely taken? _____

Vitamins or supplements currently taking:_____

Any allergies to medications? _____

MENTAL HEALTH HISTORY

Has the child/client ever received medications for behavioral/emotional concerns? NO YES

Medication Name	Dosage	Purpose	Date Started	Prescribed By

Are you satisfied with the child's psychiatric care? NO YES _____

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Has the child/client ever received counseling or psychotherapy for behavioral/emotional concerns? NO YES

Provider Name	Treatment Dates	In what ways was treatment effective and ineffective?

Has a parent or other family member(s) received medication, counseling or psychotherapy? NO YES

Has anyone in the patient's family (including parents, siblings, grandparents, uncles, aunts) ever been diagnosed with any of the following conditions? (circle all that apply)

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) LEARNING PROBLEMS DEPRESSION
ANXIETY MANIC DEPRESSION/BIPOLAR ALCOHOL/DRUG ABUSE SCHIZOPHRENIA
OBSESSIVE-COMPULSIVE DISORDER (OCD) NONE

Does anyone in the immediate family/household have concerns related to substance abuse? NO YES

Please explain: _____

LEGAL/VICTIM ISSUES

Has the child/client had any law violations or contact with law enforcement? NO YES _____

Do parents of other family members have legal violations? NO YES _____

Has the child/client experience neglect, physical or sexual abuse or witnessed domestic violence? NO YES

_____

Has Child Protective Services (CPS) ever been involved with the family or child/client? NO YES

_____

Substance Use/Abuse by child/client? Circle the one that best describes the child/client's use.

Caffeine: daily weekly occasionally once or twice never

Nicotine/Cigarettes: daily weekly occasionally once or twice never

Alcohol: daily weekly occasionally once or twice never

Other drugs (marijuana, K2, inhalants, cocaine, meth, etc): daily weekly occasionally once or twice never

Misuse of prescription or over the counter drugs: daily weekly occasionally once or twice never

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SLEEP INFORMATION

Does your child have a bedtime routine? NO YES

What time does your child typically go to bed? _____ What time does he/she typically fall asleep? _____

What time does he/she typically wake up in the morning? _____ Does the child snore loudly? NO YES

Does the child typically wake up in the middle of the night? NO YES How often? _____

Does the child typically take a nap each day? NO YES How long? _____

BEHAVIORAL HELATH INFORMATION

Describe the best things about the child/client? _____

_____

Please list the clubs/group and favorite activities of your child. _____

_____

Child/client's work or volunteer experiences? _____

Community resources (e.g., YMCA, Food Bank, Region V, etc) and church activities: _____

_____

Religious preference: _____

Which of the following ***have recently been*** or ***currently are*** problems with your child?

	Never	Some	Often	Always		Never	Some	Often	Always
Won't mind	____	____	____	_____	Suicidal Thoughts	____	____	____	_____
Too active	____	____	____	_____	Nervous	____	____	____	_____
Anger/Temper	____	____	____	_____	Cries a lot	____	____	____	_____
Clumsy	____	____	____	_____	Harms self	____	____	____	_____
Destructive	____	____	____	_____	Very shy	____	____	____	_____
Easily upset	____	____	____	_____	Clings to parent(s)	____	____	____	_____
Toileting issues	___	____	____	_____	Nightmares	____	____	____	_____
Impulsive	____	____	____	_____	Aggressive to others	____	____	____	_____
Other: _____					Other: _____				

Nutrition/Wellness Activities

Please tell us about the following for your child.

How many times per week does your child eat fast food? ___ Does he/she take a multi-vitamin? ____

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How many times per week does he/she get 30 minutes or more of physical exercise? _____

How much soda does he/she consume in a day? ____ Energy drinks? ____ Coffee? ____

How many minutes/hours does he/she spend watching television daily? __ Computer? ___ Video games? ___

How many ***uninterrupted*** hours of sleep does he/she get daily? ____

How many hours does he/she spend with friends? ____

How many minutes/hours does he/she spend quietly with themselves daily? ____

How does he/she relax or unwind? _____

What does he/she like to do for fun? _____

How does he/she manage stress in their life?_____

_____

Anything else you feel is important for us to know about your child?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Treatment Goals

Please list the goals/changes you hope to achieve with your child/client in therapy.

1.

2.

3.

What are your child's strengths?

1.

2.

3.

What are the strengths of the child's family/support system?

1.

2.

3.

Signature of person completing this form: _____

Print name: _____ Relationship to child: _____

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Informed Consent for Treatment

I, _____(client name), agree and consent to

participate in psychological/behavioral health care services offer and provided at/by

_____ (provider name), a behavioral health care provider with

Origins Health and Wellness, LLC.

I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the client. I have been given the opportunity to discuss the concerns I have for my treatment or the treatment of my minor child/ward. I have an adequate understanding of the treatment that is planned and agree to play an active role in this treatment as needed and give this behavioral health care provider permission to begin this treatment as shown by my signature below.

If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature of Client: _____ Date: _____

Signature of legal guardian: _____ Date: _____

Relationship to client (if applicable): _____

I, behavioral health care provider, have discussed the treatment recommendations and plan for care with the client and/or parent/guardian. My observations of this person's behavior and responses give me no reason in my professional judgment, to believe this person is not fully competent to give informed and willing consent for their own treatment or that of their minor child/ward.

Signature of Provider: _____ Date: _____

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Insurance Release of Information/Assignments of Benefits

I authorize Origins Behavioral Health and Wellness, L.L.C., to release to my Medicare/Medicaid or any other insurance carrier, any medical information needed for authorization or payment of this or a related claim. I authorize payments directly to this office for the mental health benefits. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

FINANCIAL AGREEMENT

Pre-Authorization for Mental Health Services:
Most insurance companies require pre-authorization for mental health services. As part of your care, Origins will conduct a verification of benefits to determine your coverage, copays, and deductible information. You will be contacted if your participation in this process is necessary. Should you have any questions, please contact our billing department.

Payment of Services:
Clients are required to pay all co-pays, co-insurance, and balances on account at the time of service. In the event that payment cannot be made, a statement will be mailed and payable within 10 days of receipt. I f payment cannot be made when due, you must contact our billing department and set up a payment plan. After 90 days, if no payment has been received, necessary collection proceedings will begin. It is important that you notify us of any address changes promptly since undeliverable statements are turned over to collections immediately.

Insurance:
If you have insurance and are using it to pay for your services at Origins, we will complete and submit an insurance claim on your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up and all charges not covered by your insurance. Origins will conduct an initial verification of benefits. After that, any issues with coverage or payment of services will be your responsibility. It is often the case that insurance benefits for mental health are different from primary care. If you do not receive an explanation of benefits from you insurance company within 30 days of your date of service, please follow up with your insurance on the delayed claim. After you have spoken with your insurance company, please contact our billing department at 402.489.9990 option 1, option 2, to inform us of the progress on the claim. Origins Behavioral Health and Wellness, LLC reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days. If you have any questions regarding your account or the filing of your insurance claims, please contact us at 402.489.9990, option 1, option 2. We will be happy to assist you.

Appointment No-Show Fee:
Everyone's time is valuable. In conducting our business, we must schedule clients in advance and assume that those appointment times will be respected. When they are not, other clients who are awaiting an appointment time are forced to wait unnecessarily. In an effort to encourage attendance and/or respectful cancellation of appointments, you will be charged $75.00 for any appointments missed that are not cancelled 24 hours in advance

I have been advised that this office requires a 24-hour prior notice on all appointment cancellations. I have been advised that there will be a $75.00 no show fee for all appointments that are canceled with less than 24 hour notice. This fee is not covered by any insurance plan.

I understand and agree to abide by the above Insurance Release of Information/Assignment of Benefits and the Financial Agreement.

_____ _____

Signature of Client/Guardian/Guarantor Date

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Acknowledgement of Review of Notice of Privacy Practices, Patient Rights and Responsibilities, and Magellan Member Rights and Responsibilities

Client's Name: _____ Client's DOB: _____

☐ ***Notice of Privacy Practices:** I have been given the opportunity to review Origins' Notice of Privacy Practices for Protected Health Information. I understand that Origins has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy from the front office during normal business hours.

☐ ***Client Rights and Responsibilities:** I have been given the opportunity to review Origins' Client Rights and Responsibilities. I understand that Origins has the right to change the Client Rights and Responsibilities at any time and that I may obtain a current copy from the front office during normal business hours.

☐ ***Managed Care Company Rights and Responsibilities**: I have been given the opportunity to review the Rights and Responsibilities of my Managed Care Company I understand that I may obtain a current copy at the front office during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the client, client's guardian, power of attorney, parent or is duly authorized by or on behalf of the client to execute the above and accept its terms.

Client/Guardian Signature: _____

Printed Name: _____ Date: _____

*HIPPA Privacy Practices, Origins' Client Rights and Responsibilities, and the Rights and Responsibilities of your respective Managed Care Company are available at our office for your review. Please let us know at your first appointment if you would like to review these documents.

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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan and medication, if applicable.

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP.

My Primary Care Physician is _____.

Address _____.

Telephone Number _____.

☐ I agree to release only medication information to my PCP.
☐ I WAIVE NOTIFICTION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.
☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

_____

Patient Signature Date

Patient Rights:

- You can end this authorization (permission to use or disclose information) any time by contacting Origins Health & Wellness, LLC at 402.489.9990.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose information.

Information to be completed by Behavioral Health Provider

☐ PCP letter sent on _____ (date mailed/emailed).
☐ Copy of letter in client file.
☐ Staff initials _____.

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