SCH Shenandoah Community Health | School-Based Health

Dear Parent and/or Guardian,

Shenandoah Community Health (SCH) is pleased to partner with Morgan County Schools to offer school-based behavioral health services in your child's school this year. This is an exciting opportunity to ensure access to mental healthcare and offer convenience for busy households because healthy kids make successful students!

A licensed Psychiatric Mental Health Nurse Practitioner will be available at the school during the days/times listed below to provide behavioral health services such as:

- Treatment evaluations
- Monthly appointments
- Medication management
- Intake assessments

Our school-based behavioral health provider will work in conjunction with your child's regular primary care provider (PCP), when applicable, to coordinate and enhance their overall care.

All students enrolled in the school-based health program are eligible to receive services regardless of insurance status. Shenandoah Community Health accepts most commercial insurance plans, including PEIA, as well as Medicaid, Medicare and offers a sliding fee discount program for those who qualify; finances are never a barrier to care at SCH.

Parents are welcome to accompany their student for scheduled appointments during SBH hours.

All parts of this enrollment packet must be completed, signed, and returned to the school or by mail to the address below before your child can receive services.

Shenandoah Community Health
Attn. School-Based Health Coordinator
P.O. Box 1146
Martinsburg, WV 25402

For questions or more information call 304.263.7023 or email schoolhealth@svms.net.

SCH School-Based Behavioral Health will be at Widmyer Elementary on Thursdays from 8am-12pm.

SCH Shenandoah Community Health | School-Based Health

SCHOOL-BASED BEHAVIORAL HEALTH SERVICES CONSENT/ENROLLMENT

Please check Yes or No after each statement and sign at the bottom	Yes	No
I give permission for my child to be treated by the school-based mental health provider. A brief health history will be conducted during initial visit.	☐	☐
I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school based health staff if any of my child's medical history changes.	☐	☐
Authorization for Exchange of Health & Education Information: I hereby authorize SCH to exchange health and education records with my child's school district for the purpose of providing care and treatment and educational services to my child, if applicable.	☐	☐
Authorization for Exchange of Health Information: I hereby authorize SCH to exchange health care records with my child's PCP (Primary Care Provider) for the purpose of continuity of care and treatment of my child, as needed.	☐	☐

My student's Primary Care Provider is: _____ **Phone #** _____

This authorization is valid until I revoke this authorization or until my child no longer attends this school. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. Any changes to parent/guardianship, address/phone number, or any change in medical information is my responsibility to inform SCH School Based Health Center. I recognize that health records if received by the school district may not be protected by the HIPAA Privacy Rules, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Does your student:

Have any medication/drug allergies? If so, what are they allergic to? _____

Have any other allergies we should be aware of (eggs, bees, etc)? _____

Take any medications on a daily basis? _____

Have any chronic illnesses (Asthma, Diabetes, Anemia, etc.) _____

Parentor Legal Guardian Signature	Student Signature (If over 18)
Print Name	**Date**

SCH
Shenandoah
Community Health®

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / PREFERRED NAME

SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS

While Shenandoah Community Health recognizes a number of gender sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different, please let us know.

BIRTH SEX (Circle One)	CURRENT GENDER (Circle One)	PREFERRED PRONOUN (Circle One)
Male Female	Male Female	He, Him, His She, Her, Hers They, Them, Theirs Other
Undifferentiated Unknown	Undifferentiated	Ze, Hir (Gender Free) Asked but unknown Decline to Answer

GENDER IDENTITY	SEXUAL ORIENTATION
☐ Male ☐ Transgender Male/Female-to-Male ☐ Other	☐ Lesbian or Gay ☐ Don't Know
☐ Female ☐ Transgender Female/Male-to-Female	☐ Straight (not lesbian or gay) ☐ Choose not to disclose
☐ Non-binary ☐ Choose not to disclose	☐ Bisexual ☐ Something else, please describe _____

BILLING ADDRESS	CITY, STATE, ZIP	PHONE NUMBER

SECONDARY ADDRESS	CITY, STATE, ZIP	PREFERRED CONTACT METHOD

MARITAL STATUS (Circle One)	PRIMARY LANGUAGE (Circle One)
Single Married Widowed	English Spanish American Sign Language Creole Haitian Creole
Divorced Legally Separated	Other:_____

EMERGENCY CONTACT NAME	TELEPHONE	RELATIONSHIP

PREFERRED PHARMACY	PRIMARY CARE PROVIDER

HOUSING STATUS	RACE
☐ Not Homeless ☐ Doubling Up	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Transitional ☐ Shelter	☐ Other Pacific Islander ☐ White ☐ Other: _____
☐ Street	

MIGRANT WORKER STATUS	ETHNICITY
☐ Migrant ☐ Seasonal	☐ Not Hispanic Or Latino ☐ Hispanic Or Latino

LANGAUGE BARRIER (Circle One)	ARE YOU A MILITARY SERVICE VETERAN? (Circle One)
YES NO	YES NO

CHIEF COMPLAINT/REASON FOR VISIT

REFERRAL SOURCE

Over

HOUSEHOLD SIZE AND ANNUAL FAMILY INCOME	
FAMILY SIZE: _____	**ANNUAL FAMILY INCOME: $_____**

We are required by funding agencies to obtain the following information from our patients for statistical purposes. This will help us secure grants to support outreach and programs for patients with special needs. Your individual information remains private and confidential and is not shared with any agency or organization.

RESPONSIBLE PARTY INFORMATION (If Different Than Patient)		
NAME (Last, First, Middle)	SSN#	BIRTHDATE
ADDRESS	CITY, STATE, ZIP	TELEPHONE
RELATIONSHIP TO PATIENT		

PLEASE SHOW ALL INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID # GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED (EMPLOYEE, IF THROUGH WORK)		RELATIONSHIP OF PATIENT TO INSURED	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)			
NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID # GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED		RELATIONSHIP TO PATIENT	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SCH Shenandoah Community Health | Behavioral Health

PATIENT BILL OF RIGHTS

Shenandoah Community Health – Behavioral Health is committed to providing professional services of the highest quality in a way that recognizes the dignity and rights of each person we serve. As a patient, **you have the right to:**

1. Be served by qualified staff.
2. Have a treatment plan, or plan of services, developed for you as an individual, based on your needs, and participate in setting your treatment goals and working toward them.
3. Know the name and professional status of the persons providing your mental health treatment and the method of and purpose of the treatment modality proposed for you. You have the right to know what benefits you may expect from services and of any undesirable or harmful effects which may occur as a result of treatment and medication.
4. Refuse treatment recommended for you except in cases where a valid petition for emergency evaluation has been obtained.
5. Have your treatment record and all information about you kept confidential. Information will be released only with a signed release of information, except in those circumstances where a dangerous/emergency situation exists, or your treatment is mandated as a condition of probation or parole.
6. Under the law, mental health staff is required to report to the Department of Social Services if they have a reason to suspect that a child or vulnerable adult has been abused.
7. Refuse to participate in physically optional research.
8. Be informed, at your first visit, what fees you will be charged based on your ability to pay.
9. Raise questions concerning the nature of your treatment, and should your treating therapist/physician not satisfactorily answer your concerns, you have the right to bring your grievances to the Clinical Supervisor or Program Director. A copy of the Patient Grievance Procedure is available to you any time at the reception desk.
10. Obtain complete and current information concerning your diagnosis, and treatment in terms that can be understood.
11. Follow your religious beliefs. Treatment plan collaboration with the patient's clergy may be requested by the patient.
12. Be assessed and treated for pain.

I have read, acknowledge and have been advised of the above patient's rights.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

SCH Shenandoah Community Health | Behavioral Health

Consents

I hereby give consent for myself, or a minor, to receive the services of Shenandoah Valley Medical System, Inc. that does business as Shenandoah Community Health (SCH) for an initial evaluation and all follow-up care that is required, including but not limited to psychopharm evaluation/medication and/or therapy.

Patients who are unable to keep a scheduled appointment must cancel prior to 24 hours of the appointment. Appointments cancelled less than 24 hours in advance, or not all, may subject the patient to scheduling restrictions after the third occurrence.

I acknowledge that I am aware SCH's "*Notice of Privacy Practices*" for protected health information is available in the waiting area of each department or on the website at shencommhealth.com. A printed copy is available by request.

I authorize staff of SCH to take my picture or scan my photo ID and place it in my Electronic Medical Record for purposes of identification. In addition, I also give consent to SCH to take photographs of rashes, endoscopy, colonoscopy, and other medical images for the purpose of medical documentation. I understand that photographs will be protected as part of my medical record and unless otherwise required by federal or state law as noted in the SCH "*Notice of Privacy Practices,*" will not be released without my authorization.

During the course of care and treatment, I understand that various types of examinations, tests, diagnostics or procedures may be necessary. This may include, but is not limited to, hearing and/or vision screening, laboratory testing, urine drug screening, injections, and other testing that the provider deems necessary. If I have any questions concerning these procedures, I will ask my clinician to provide me with additional information. I also understand my provider may ask me to sign additional Informed Consent documents related to specific procedures.

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I authorized payment of insurance benefits to Shenandoah Valley Medical System, Inc. for medical services rendered to me. I understand that I am responsible for payment of fees for medical services rendered to me that are not covered by insurance or other third party payers, including copay, deductible and non-covered amounts.

If the client is a minor, a parent/legal guardian is aware and consent to this treatment.

Patient Name	Date of Birth
Signature	Date
Mother/Legal Guardian Signature (if patient is a minor)	Date
Father/Legal Guardian Signature (if patient is a minor)	Date
Witness	Date

Telehealth Informed Consent

I _____hereby consent to engage in telehealth with Shenandoah Community Health. I understand that "telehealth" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of telehealth visit is confidential.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of Shenandoah Community Health, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that telehealth based services and care may not be as complete as face- to-face services. I also understand that if my provider believes I would be better served by another form of services (e.g. face-to-face services) I will be informed to schedule a face to face visit by the provider.
5. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
6. I accept that telehealth does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my telehealth sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.
8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

Your provider will again request your verbal consent or denial of information contained in this document at the beginning of your telehealth visit.

If the client is a minor, a parent/legal guardian is aware and consent to this treatment.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

_____ _____

Parent or Legal Guardian Signature (if patient is a minor) Date

_____ _____

Witness Date

SCH Shenandoah Community Health | Behavioral Health

When Your Child Needs Counseling
Guidelines For Therapy

Evaluation Process

The evaluation process for a child brought to therapy generally takes at least 3-4 sessions. The parents' and/or caregivers' participation is an important part of this process. Others involved in the child's daily life may also be asked to participate in the evaluation process. These people may include relatives, teachers, daycare providers, doctors, or social workers. The initial meeting is generally with the parents only and the second session with the child.

Treatment Process

Upon completion of the evaluation, the therapist and parents (or caregivers) will meet and discuss the findings of the evaluation and the need for therapy. The child is not present at this meeting so that all may talk freely about the child and their needs.

If ongoing therapy is indicated, a weekly schedule will be set up with an appointment for the child set at the same day and time. This regular weekly time becomes the child's time, optimizing the opportunity for the child to develop a trusting relationship with the therapist in which to talk about or "play out" their worries or struggles. A child's way of talking about their worries is through play, so it is fine if your child chooses to mostly play rather than talk.

Maintaining a weekly session is very important; as missed sessions may delay the rapport-building process, critical to the effectiveness of therapy. Therapy is much like taking an antibiotic or other medicine – it is important for it to be consistent in order for it to be effective.

In addition to the child's weekly session, there will be a need for parent-only sessions, from weekly to monthly, depending on the problems we are working on. During these sessions we will discuss your child's progress, whether or how to make changes at home or school, and discuss any concerns you may have.

During the course of your child's therapy, parent/child sessions may also be recommended. The only way to effectively treat your child is with parental involvement. Children's problems (whether biologically based or emotionally-based) are impacted by the home and school environment. Helping the family and school make changes often helps the child make changes too.

Please See Other Side

Ending Therapy
Many children who enter therapy remain for several months to a couple of years, depending on the problem they are working on. Ending treatment is an important process, and needs to be discussed in advance of the actual ending of treatment. The number of sessions needed to end treatment depends on the child's maturity/age, and generally ranges from 3-6 sessions. An abrupt ending to treatment is often upsetting and confusing to the child, and may undo some of the work that was accomplished.

Policies / Procedures
Cancellations are required 48 hours prior to the appointment time. Late cancellations or missed appointments may result in the loss of your regular weekly appointment time. This includes cancellations made due to illness. If your child is ill and can not attend their session, it is recommended that the parent attend in their place so as not to lose the appointment time. If there are repeated missed appointments without proper notification, we will need to discuss whether we can continue to provide therapy services through our agency. This policy is necessary as we cannot fill the cancelled appointment times without at least 48 hours notice and we cannot bill for missed or cancelled appointments.

Confidentiality
We strictly observe the principle of confidentiality of any and all information we have about a client. Information will not be released to anyone without written permission from the client (or parent if the client is a child under 16). However, information concerning danger to the client or others, must in some cases be reported.

Questions and Comments
Please feel free to ask your therapist about his or her qualifications and training. You are also encouraged to share any comments, reactions, or feedback you may have about any aspect of your child's therapy. Your feedback is very important and is helpful in making the treatment process successful.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE GUIDELINES AND PROCEDURES. I HAVE BEEN GIVEN AN OPPORTUNITY TO DISCUSS THEM AND I HAVE BEEN PROVIDED A COPY OF THEM.

CLIENT (IF ADULT 16 OR OLDER)	**DATE**
PARENT / CAREGIVER	**DATE**
THERAPIST	**DATE**

Child & Adolescent Evaluation: Patient Form	
Patient:	**Date:**

Today's Date: / /	**This form filled out by:**		**Referred by:**	
Name:		**Sex:**	**Age:**	**Date of Birth:** / /
Persons present for evaluation:				

Briefly describe the events that led to this appointment.	**Clinician Use**
What concerns you most about your child?	
What are your goals for this evaluation?	
Have there been previous mental health contacts? If yes, list these contacts and approximate dates of treatment (include hospitalization dates). What were the results of treatment?	
Please list pertinent medications, approximate doses, and dates of treatment.	

Social History	**Clinician Use**
List the names and ages of individuals living in the household. Please include relationship to the child.	
Who are the legal guardians of the child?	
List immediate relatives (biological or related by marriage, parents or siblings) or other primary caretakers of the child outside the primary home.	

Child & Adolescent Evaluation: Patient Form	
Patient:	**Date:**

Are there any particular stresses or recent changes in the family? For instance job, changes, financial problems, a move to a new home, health problems, marriage or divorce, violence, or substance abuse.	
Who is responsible for discipline in the home? What methods have and have not worked?	

Family History	**Clinician Use**
Please identify if there is a history of any of the following in the child's family. Briefly describe the problem and relative (for example, seizures in a maternal aunt).	
Alcohol or drug abuse?	
Eating problems?	
ADHD or school behavior problems?	
Conduct problem or legal problems?	
Mental retardation, learning disabilities, or other developmental problems?	

Child & Adolescent Evaluation: Patient Form	
Patient:	**Date:**

Mood problems, including suicide, depression, or bipolar disorder?	
Anxiety or panic problems?	
Schizophrenia?	
Neurological Problems, such as seizures, migraines, or tics?	
Genetic syndromes?	
Heart or other medical problems?	

Developmental History			**Clinician Use**
Birth Weight:	Birth Length:		
Current Weight:	Current Height:		
Have there been any issues with the child's height or weight?	☐ Yes	☐ No	
If yes, what?:			
Were there any complications with the pregnancy or the child's delivery (for example: use of alcohol or drugs during pregnancy, medications, premature birth, fetal distress, C-section, or low apgars)?			

Please Indicate at what age the child began the following:			
Crawling:		Has the child had any problems crawling or walking?	☐ Yes ☐ No
Walking:			
If yes, what problems?			
Has the child had any problems with motor skills?			☐ Yes ☐ No
If yes, what problems?			
Eating:		Has the child had any problems nursing or eating?	☐ Yes ☐ No
Feeding Self:			
If yes, what problems?			
Talking:		Has the child had any problems speaking or reading?	☐ Yes ☐ No
Reading:			
If yes, what problems?			
Toilet Trained:		Has the child had any problems with toilet training?	☐ Yes ☐ No
If yes, what problems?			
Began sleeping through the night:		Has the child had any problems sleeping?	☐ Yes ☐ No
If yes, what problems?			
First time apart from parents:		Has the child had any problems being apart from parents?	☐ Yes ☐ No
If yes, what problems?			

Child & Adolescent Evaluation: Patient Form	
Patient:	**Date:**

Education History/Status	Clinician Use
What School does your child attend and who is your child's teacher? Who is your child's guidance counselor?	
What grade is your child currently in?	
Has your child had to repeat any grade levels? If so, which grade levels and how many times?	
How are your child's grades now?	
What have your child's grades been like in the past? Has there been a sudden change in your child's grades?	
Has your child ever gotten in trouble at school for behavioral reasons? (For instance acting out, not following school rules or teacher requests, or fighting) What consequences were received for these behaviors?	
How does your child get along with teachers, school staff, and other students?	
Has you child been involved with a student assistance tem or had an Individual Education Plan (IEP) or 504 meeting? If so, when and what were the results of this?	

Has your child received any educational or psychological testing? If so when, by whom, and what were the results?	
What are your child's academic strong points and problem areas?	

How well does you child get along….	
With siblings?	
With peers?	
With parents?	
With other adults or family?	
By himself/herself?	
Does your child have any hobbies or activities they are involved in?	

Spirituality/Religion	**Clinician Use**
Does the family believe in a particular religion or spiritual belief? If so are you affiliated with a particular organized group?	
Is your child involved in this belief? Do they participate in religious/spiritual activities? Does your child express a desire to learn more about and become more involved in religion/spirituality?	
Has you child expressed any particular opinions or feelings regarding this or another religion/spirituality? Is this a source of hope, meaning, comfort, or connection for them?	

Child & Adolescent Evaluation: Patient Form	
Patient:	**Date:**

Legal Status	Clinician Use
Has your child had any involvement with the police or court system? If so what were the circumstances that led to the involvement? Was your child convicted of a charge?	
Has your child ever been placed out of the home due to legal problems? If so where, when, and for how long?	
Is your currently on probation or an improvement period? Has you child ever been placed on either of these programs in the past? Is or has you child been compliant with these programs?	
If your child is currently involved with probation, who is the probation officer? Please include phone number.	
Has your child been in trouble with the law because of a violent act against another, arson, property damage, or animal cruelty? What are the circumstances of those events?	

Child & Adolescent Evaluation: Patient Form	
Patient:	**Date:**

Medical History	**Clinician Use**
Child's Pediatrician:	
Address:	
Phone:	
Date of last physical exam: / /	
Were any problems found during the examination?	
Are the child's immunizations up to date? ☐ Yes ☐ No	
If not what immunizations are not up to date?	
Does the child have any medical conditions? If yes explain.	
Have there been any medical problems in the past? If yes explain.	
Please list current medications and doses.	
Does you child have any past or present medical complaints, such as headaches, head or other major injuries, seizures, ear infections, heart or breathing problems, or any gastrointestinal problems?	
Has the child's vision and hearing been evaluated? What were the results?	