



| PATIENT INFORMATION   |  |   |                            |  |                          |
|---|--|---|----------------------------|--|--------------------------|
| LAST NAME   |  | FIRST NAME  | MIDDLE NAME / INITIAL      | PREVIOUS NAME / NICKNAMES(S)               |                          |
| SOCIAL SECURITY #   |  | BIRTHDATE (MM/DD/YYYY)  |                            | EMAIL ADDRESS                              |                          |
|   |  |   |                            | BIRTH SEX (Circle One)<br>Male      Female |                          |
| ADDRESS   |  |   | CITY, STATE, ZIP           |  | PHONE NUMBER             |
| BILLING ADDRESS (If Different Than Above)   |  |   | CITY,STATE,ZIP             |  | PREFERRED CONTACT METHOD |
| MARITAL STATUS (Circle One)<br>Single      Married      Widowed<br><br>Divorced      Legally Separated  |  | PRIMARY LANGUAGE (Circle One)<br>English      Spanish      American Sign Language      Creole      Haitian Creole<br><br>Other: _____   |                            |  |                          |
| EMERGENCY CONTACT   |  | NAME  |                            | TELEPHONE                                  | RELATIONSHIP             |
| PREFERRED PHARMACY  |  | PRIMARY CARE PROVIDER   |                            |  |                          |
| HOUSING STATUS<br><input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up<br><input type="checkbox"/> Transitional <input type="checkbox"/> Shelter<br><input type="checkbox"/> Street |  | RACE<br><input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian<br><input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ |                            |  |                          |
| MIGRANT WORKER STATUS<br><input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal   |  | ETHNICITY<br><input type="checkbox"/> Not Hispanic Or Latino <input type="checkbox"/> Hispanic Or Latino  |                            |  |                          |
| LANGAUGE BARRIER (Circle One)<br>YES      NO  |  | ARE YOU A MILITARY SERVICE VETERAN? (Circle One)<br>YES      NO   |                            |  |                          |
| HOUSEHOLD SIZE AND ANNUAL INCOME  |  |   |                            |  |                          |
| NUMBER LIVING IN HOUSEHOLD: _____   |  |   | HOUSEHOLD 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 |

**SIGN** \_\_\_\_\_ **DATE** \_\_\_\_\_



Shenandoah Valley Medical System, Inc. does business as Shenandoah Community Health (SCH). This health center receives Health and Human Services funding and has Federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. SCH is an equal opportunity provider, serving all patients regardless of ability to pay.

## Consents

I hereby give consent for myself to receive the services of Shenandoah Valley Medical System, Inc. that does business as Shenandoah Community Health (SCH).

Patients who are unable to keep a scheduled appointment must cancel the day prior to the appointment. Appointments cancelled the day of, 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.

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Patient Name

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Date of Birth

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Signature

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Date

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Mother/Legal Guardian Signature (if patient is a minor)

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Date

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Father/Legal Guardian Signature (if patient is a minor)

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Date

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Witness

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Date



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## 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





## 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



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## 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**

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|--|--------------|
| <b>Child &amp; Adolescent Evaluation: Patient Form</b> |              |
| <b>Patient:</b>  | <b>Date:</b> |

**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.**

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**CLIENT (IF ADULT 16 OR OLDER)**

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**DATE**

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**PARENT / CAREGIVER**

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**DATE**

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**THERAPIST**

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**DATE**



|  |  |                                 |              |                           |
|--|--|---------------------------------|--------------|---------------------------|
| <b>Child &amp; Adolescent Evaluation: Patient Form</b> |  |                                 |              |                           |
| <b>Patient:</b>  |  |                                 | <b>Date:</b> |                           |
| <b>Today's Date:</b><br>/ /                            |  | <b>This form filled out by:</b> |              | <b>Referred by:</b>       |
| <b>Name:</b>   |  | <b>Sex:</b>                     | <b>Age:</b>  | <b>Date of Birth:</b> / / |
| <b>Persons present for evaluation:</b>                 |  |                                 |              |                           |

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| Briefly describe the events that led to this appointment.  | <b>Clinician Use</b> |
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| What concerns you most about your child?   |                      |
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| What are your goals for this evaluation?   | <b>Clinician Use</b> |
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| 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? |                      |
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| Please list pertinent medications, approximate doses, and dates of treatment.  | <b>Clinician Use</b> |
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| <b>Social History</b>  | <b>Clinician Use</b> |
| List the names and ages of individuals living in the household. Please include relationship to the child.  |                      |
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| Who are the legal guardians of the child?  |                      |
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| List immediate relatives (biological or related by marriage, parents or siblings) or other primary caretakers of the child outside the primary home. | <b>Clinician Use</b> |
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| <b>Child &amp; Adolescent Evaluation: Patient Form</b> |              |
| <b>Patient:</b>  | <b>Date:</b> |

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| 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. |  |
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| Who is responsible for discipline in the home? What methods have and have not worked?   |  |
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|---|----------------------|
| <b>Family History</b>   | <b>Clinician Use</b> |
| <i>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).</i> |                      |
| Alcohol or drug abuse?  |                      |
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| Eating problems?  |                      |
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| ADHD or school behavior problems?   |                      |
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| Conduct problem or legal problems?  |                      |
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| Mental retardation, learning disabilities, or other developmental problems?   |                      |
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| <b>Child &amp; Adolescent Evaluation: Patient Form</b> |              |
| <b>Patient:</b>  | <b>Date:</b> |

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| Mood problems, including suicide, depression, or bipolar disorder? |  |
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| Anxiety or panic problems?   |  |
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| Schizophrenia?   |  |
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| Neurological Problems, such as seizures, migraines, or tics?       |  |
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| Genetic syndromes?   |  |
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| Heart or other medical problems?                                   |  |
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| Developmental History  |                              | Clinician Use               |  |
|--|------------------------------|-----------------------------|--|
| Birth Weight:  | Birth Length:                |                             |  |
| Current Weight:  | Current Height:              |                             |  |
| Have there been any issues with the child's height or weight?  | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)? |                              |                             |  |
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**Child & Adolescent Evaluation: Patient Form****Patient:****Date:****Please Indicate at what age the child began the following:**Crawling:  Has the child had any ☐ Yes ☐ NoWalking:  problems crawling or 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 ☐ Yes ☐ NoFeeding Self:  problems nursing or eating?

If yes, what problems?

Talking:  Has the child had any ☐ Yes ☐ NoReading:  problems speaking or reading?

If yes, what problems?

Toilet Trained:  Has the child had any ☐ Yes ☐ No

problems with toilet training?

If yes, what problems?

Began sleeping through the night:  Has the child had any ☐ Yes ☐ No

problems sleeping?

If yes, what problems?

First time apart from parents:  Has the child had any ☐ Yes ☐ No

problems being apart from parents?

If yes, what problems?

|  |              |
|--|--------------|
| <b>Child &amp; Adolescent Evaluation: Patient Form</b> |              |
| <b>Patient:</b>  | <b>Date:</b> |

| <b>Education History/Status</b>   | <b>Clinician Use</b> |
|---|----------------------|
| What School does your child attend and who is your child's teacher?<br>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?  |                      |
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|   |                      |
|   |                      |
| What have your child's grades been like in the past? Has there been a sudden change in your child's grades?   |                      |
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| 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? |                      |
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| How does your child get along with teachers, school staff, and other students?  |                      |
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| 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?  |                      |
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| <b>Child &amp; Adolescent Evaluation: Patient Form</b> |              |
| <b>Patient:</b>  | <b>Date:</b> |

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|---|--|
| Has your child received any educational or psychological testing? If so when, by whom, and what were the results? |  |
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| <b>What are your child's academic strong points and problem areas?</b>  |  |
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| How well does your 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? |  |
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|---|----------------------|
| <b>Spirituality/Religion</b>  | <b>Clinician Use</b> |
| Does the family believe in a particular religion or spiritual belief? If so are you affiliated with a particular organized group?   |                      |
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|   |                      |
|   |                      |
| 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? |                      |
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| Has your 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?                     |                      |
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| <b>Child &amp; Adolescent Evaluation: Patient Form</b>   |                      |                      |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|----------------------|----------------------|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>Patient:</b>  | <b>Date:</b>         |                      |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Child & Adolescent Evaluation: Patient Form****Patient:****Date:****Medical History**

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 your 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?

**Clinician Use**