AGAPE YOUTH BEHAVIORAL HEALTH
& COMPREHENSIVE PSYCHIATRIC CARE

Patient Information

Child's Name	Date of Birth	Age
School	Grade	
Referring Provider		
Primary Care Doctor	Therapist (if any)	

Mental Health Concerns and History

1. Please list your child's main symptoms/behaviors of concern:

2. What is your primary goal for this appointment?

3. Check below all services that you are interested in for your child:

☐Clarification of Diagnosis ☐Medication Treatment ☐Information About Psychotherapy/Behavioral Training

4. What mental health diagnoses has your child previously been given or do you suspect?

5. List all clinics or mental health centers that your child has been treated at previously:

Clinic or Center	Estimated Dates of Visits

6. Has your child ever had inpatient or residential treatment for **mental health** symptoms? ☐ Yes ☐ No

Facility	Reason for Hospitalization	Dates of Stay

7. List **all current** medications/supplements and doses below:

Medication	Dose (how much & how often)

8. List all **past medications/supplements** used for **emotional or behavioral problems** below (use blank paper if needed):

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped

Allergies, Medications, and Medical Concerns

1. Please list any known **medication** allergies or sensitivities: ☐ None
2. Please list any **other** known allergies (foods, seasonal): ☐ None
3. Please list any medical illnesses that your child has: ☐ None
4. Has your child ever had surgery or been hospitalized for medical reasons? ☐ Yes ☐ No

Facility	Reason for Surgery or Hospitalization	Dates

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Birth and Developmental History

1. Age of biological mother at child's birth	2. Child's birth weight
3. Was biological mother exposed to toxins in pregnancy (i.e. medications, tobacco, street drugs, alcohol)? ☐ Yes ☐ No	
If yes, list toxins:	
4. Any complications during this pregnancy? ☐ Yes ☐ No List:	
5. Full-term ☐ Yes ☐ No	6. Home within 3 days of birth? ☐ Yes ☐ No
7. Please write the age at which your child was able to do the following things (if remembered)	
First walked?	Was toilet trained?
Said first words?	Used 2-3 word phrases with meaning?
8. Has your child ever had **psychological or IQ testing**? If so, please provide copies. Yes No	

Educational and Social History

1. Has your child ever received any special education services at school? ☐ Yes ☐ No		
2. Does your child have an IEP (Individualized Education Plan)? ☐ Yes ☐ No		
3. Has your child ever repeated a grade level? ☐ Yes ☐ No		
4. Has your child ever received any of the following services listed below:		
Physical Therapy ☐ Yes ☐ No	Speech Therapy ☐ Yes ☐ No	Occupational Therapy ☐ Yes ☐ No
5. Has your child had significant disciplinary actions (i.e. suspensions, expulsions) at school? ☐ Yes ☐ No		
6. Had your child had legal problems (i.e. court appearance, probation)? ☐ Yes ☐ No		
7. Is your child interested in making and keeping friends? ☐ Yes ☐ No		
8. Potential stress history for child (check all that apply):		☐ Arrest/convictions of family members
☐ Parental divorce	☐ Parent separation or marital problems	☐ Exposure to a Natural Disaster
☐ Domestic violence	☐ Serious illness in family	☐ Death in family
☐ Victim of Physical Abuse	☐ Victim of Sexual Abuse	☐ Victim of Verbal/Emotional Abuse

9. List all immediate (biological) family members. Also list others living in the home:

Relation	Name	Age	Living in Home?	Children: current grade in school Adults: highest level of education
Bio Father				
Bio Mother				

Family History

1. Please list below any biological family members of the child who have had any of the following:
   - i. Sudden death, heart rhythm problems, genetic disorders
   - ii. Autoimmune disorders (i.e. thyroid disease, lupus, multiple sclerosis)
   - iii. Psychiatric conditions (i.e. anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD)
   - iv. Developmental conditions (i.e. mental retardation, learning problems, autistic disorders)
   - v. Neurological conditions (i.e. seizures, tics)
   - vi. Drug/alcohol problems

Relationship to Child (father, mother, brother, sister, grandmother, cousin, uncle, etc.)	Name or Description of Conditions *Please include any conditions from all of the categories listed above*

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Insurance Information

****Form MUST be completed in its entirety or insurance may not pay****
If incomplete/incorrect information is provided, Parent/Guardian is responsible for payment.

Patient Information:

Last name: _____ **First:** _____ **MIddle:** _____**DOB:**_____

Race/Ethnicity: _____ **Sex:** o Male o Female **SSN:** _____-_____-_____

Address: _____**City:** _____ **State:** _____ **ZIP:** _____

Home phone: (____)_____ - _____ **Cell phone:** (____)_____ - _____ **Preferred: (CIRCLE) Home / Cell**

Parent/Guardian Information (Where billing statements will be sent):

Last name: _____ **First:** _____ **MI:** _____**DOB:**_____

Address: _____**City:** _____ **State:** _____ **ZIP:** _____

Home phone: (____)_____ - _____**Cell phone:** (_____)_____ - _____ **Preferred #:**_____

Preferred Email:_____ **Relationship to patient**:_____

SSN:_____ **Employer:**_____

Primary Insurance Policy: (Our office must have copy of FRONT/BACK)

Primary Insurance Name:_____

Member ID:_____

Policy Holder Last Name:_____**First Name**:_____**MI**:_____**Policy Holder DOB:**_____

Relationship to patient:_____ **SSN:**_____**Info**: o Same as Parent/Guardian Above

Address: _____**City:** _____ **State:** _____ **ZIP:** _____

Home phone: (____)____ - _____**Cell phone:** (____)_____ - _____**Preferred #:**_____

Secondary Insurance Policy: (Our office must have copy of FRONT/BACK)

Primary Insurance Name:_____

Member ID:_____

Policy Holder Last Name:_____**First Name**:_____**MI**:_____**Policy Holder DOB:**_____

Relationship to patient:_____ **SSN:**_____**Info**: o Same as Parent/Guardian Above

Address: _____**City:** _____ **State:** _____ **ZIP:** _____

Home phone: (____)____ - _____**Cell phone:** (____)_____ - _____**Preferred #:**_____

Patient Name:_____

Parent/Guardian Signature: _____**Date:** _____

Patient Signature (if over 18): _____ **Date:**_____

I understand that I MUST update Agape YBH immediately regarding any changes of the above information which include address, phone number, insurance changes: INITIALS:_____ **DATE:**_____

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Authorization and Informed Consent

If you are not the legal guardian, a signed consent form is required from the custodial parent. If you are divorced, a copy of the divorce agreement stating the legal guardianship is required prior to treatment. We must have copies of ALL documentation.

I agree and consent to participate in the behavioral health care services offered and provided by Agape Youth Behavioral Health. I understand that I am consenting and agreeing only to those services that my provider is qualified to provide within the scope of their license, certification, and training.

I authorize Agape Youth Behavioral Health to release to my insurance company, managed care organization, state agency(ies), Health Care Financing Administration, third party administrators, and/or Worker's Compensation or its agents, any information needed to process my claim and/or determine benefits payable to related services. I also authorize Agape Youth Behavioral Health to utilize a fax machine to transit all of the above medical records pertaining to my medical care of insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of medical records.

I grant permission for Agape Youth Behavioral Health to release all or part of my medical records to any consulting entity that may be involved in my medical care. This includes, but is not limited to the purposes of treatment, payment, and healthcare operations.

I request that payment of Medicare, Medigap, Traveler's Railroad Retirement, Managed Care Organizations, Third Party Administrators, Commercial, Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to Agape Youth Behavioral Health for services furnished to me or on behalf by that provider.

Patient Name:_____

Parent/Guardian Signature: _____**Date:** _____

Patient Signature (if over 18): _____ **Date:**_____

Notice of Privacy Practices

I have had full opportunity to read and consider the contents of this Consent Form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment, payments activities, and health care operations. I understand that questions or complaints should be directed to the privacy office.
***A copy of our Privacy Practices are available upon request.**

Patient Name:_____

Parent/Guardian Signature: _____**Date:** _____

Patient Signature (if over 18):_____ **Date:**_____

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Fee Agreement and Waiver

Please Initial:

_____ It is your obligation to stay current with your bill. Payment is due at the time services are provided. Future appointments will NOT be scheduled until your account is current. Please discuss any problems you may have with making payments, as well as any changes in your financial situation, with our billing department.

_____ It is your responsibility to notify Agape YBH 24 hours in advance if you are unable to keep your scheduled appointment. If you do not notify us, you may be billed for that session. Insurance carriers DO NOT cover missed appointments. Therefore, that portion of the bill would be your responsibility.

_____ If insurance coverage is available, we will file for insurance reimbursement. This service is a courtesy we extend to our patients, not a requirement. You MUST provide us the necessary information needed to submit to the insurance company. Failure to provide updated and accurate information will require full payment from the guarantor on the account. You are also responsible for any deductibles or copayments at the time of service.

_____ I understand that I am financially responsible for the deductible amount, co-payment, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual write-off agreement between Agape YBH and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned over to collections, I will be responsible for all costs associated with debt collection, including attorney fee(s) and court cost(s).

_____If my insurance or demographic information has changed, it is my responsibility to notify Agape YBH prior to my appointment. In instances where my plan requires pre-authorization or a referral from my primary care physician, it is my responsibility to notify the physician's office. If I do not give proper notification prior to the visit, and insurance denies a claim, I understand the bill is my obligation. This applies to all insurances.

_____ We cannot resubmit claims for dates incurred before notification of an insurance change due to guidelines for timely filing. It is my responsibility to update my coordination of benefits with my healthcare plan and give notification to Agape YBH when completed.

_____ Agape YBH has improved our billing statement process in order to better service our patients. With this, you are able to pay your bill online. In order to do so, we will need the best email for billing statements. Once started, initial statements will be sent by BOTH email and mailed statements. We will transition to ONLY emailed statements by default. If you prefer BOTH email and mailed statements, then please login and change your settings.

Patient Name:_____ **Responsible Party's Name:**_____

Responsible Party's Email (Where statements will be sent): _____

Responsible Party's Signature:_____ **Date**:_____

The website for online patient payments is www.MyProviderLink.com

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Patient Rights and Responsibilities

YOU HAVE THE RIGHT:

- To be treated with consideration, respect, and full recognition of your dignity and individuality regardless of your state of mind or condition.
- To be provided treatment without regard to race, color, birthplace, language, gender, age, religion, or disability.
- To complete privacy of your medical and financial information.
- To be informed of treatment options and/or alternative treatment methods regardless of cost or benefit coverage.
- To be informed of the risks, benefits, and consequences of treatment or non-treatment.
- To be informed of the side effects of your medication or proposed medication.
- To participate in the development of your individual treatment plan.
- To participate in all decision-making regarding your behavioral health care, including discharge or aftercare planning.
- To be provided in quality treatment by competent staff member(s).
- To refuse to participate partially or fully in treatment or therapeutic activities (unless participation is ordered by the court).
- To be provided treatment in the least restrictive setting that is clinically appropriate, feasible and available.
- To be provided a copy of your basic rights and responsibilities and to have all questions answered to your satisfaction.
- To voice complaints about your services. You can continue to receive services without fear of receiving inadequate treatment.
- To be given information about the Declaration of Mental Health treatment, or to designate a person to make decisions using a durable power of attorney for healthcare.
- To make recommendations about your rights and responsibilities.
- To be provided with a list of available advocacy services and contact information when requested.
- To ask for and receive information about your medical records, review the records, make corrections to your medical records, and to receive copies of your medical records.
- To be provided with an interpreter or any translating services free of charge to any member who needs such services, including, but not limited to, members with limited English proficiency and members who are hearing impaired.

YOU ARE RESPONSIBLE:

- To provide accurate information to your provider.
- To treat health care providers and staff with respect and dignity.
- To cancel appointments you are unable to keep in a timely manner.
- To follow instructions and guidelines given by providers.
- To participate, to the degree possible, in understanding your behavioral health problems and to develop mutually agreed upon treatment goals.

I have read the Rights and Responsibility and all my questions have been answered to my satisfaction.

Patient Name:_____

Parent/Guardian Signature: _____**Date:** _____

Patient Signature (if over 18): _____ **Date**:_____

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Patient Consent Form

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Agape YBH includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Agape YBH will use my information for the purpose of treatment, payment, and healthcare operations.

Treatment includes, but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilizations of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes, but is not limited to: the authorization of payment directly to Agape YBH of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee. I understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks. I hereby consent for billing and collection services to contact me by phone if necessary.

Healthcare operations include, but are not limited to: release of my medical information to any of my physicians and their offices, or insurance companies participating in my care or treatment and the quality of care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, physiological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

(OPTIONAL) Medicare Patients: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Agape YBH. I acknowledge that I have been given the Agape YBH Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name:_____

Parent/Guardian Signature: _____**Date:** _____

Patient Signature (if over 18): _____ **Date:**_____

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Patient Email and Text Messaging Registration Form

Agape Youth Behavioral Health has the ability to provide our patients with certain types of information via email and/or text messaging. Appointment confirmations can be sent by both email and text. We can also give access to our patient portal via email. If you wish to have the opportunity to receive this information, please complete the form below.

Agape Youth Behavioral Health believes strongly in protecting the privacy of our patients. When you prove this information, it is only used as a way to communicate with you. Patient names will be listed in appointment reminders.

Patient Name:_____

Email Address:_____

Cell Phone Number:_____

If there are multiple family members at our office, a new email must be used for each family member. Emails cannot be duplicated in multiple charts.

Please initial your choice below regarding email:

_____ Yes, please sign me up to receive emails from Agape YBH.

_____ No, I do not wish to receive emails from Agape YBH.

_____ Yes, please give me access to the patient portal through my email.

_____ No, I do not want patient portal access.

Please initial your choice below regarding cell phone number:

_____ Yes, please sign me up to receive text messages from Agape YBH.

_____ No, I do not wish to receive text messages from Agape YBH.

I hereby give Agape Youth Behavioral Health permission to send messages to me via email and/or text messaging as means of communication as indicated by my selections above.

Patient Name:_____

Parent/Guardian Signature: _____**Date:** _____

Patient Signature (if over 18): _____ **Date**:_____

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Refill Policy:
Refills **must** be left on the appropriate provider's refill line. Providers have until the end of the next business day from the day the refill request was **received** to send in refills. For example: If the request voicemail is left on **Friday**, the prescription will be sent by the end of the day on **Monday**. If you **missed** your last appointment, it is up to the discretion of the provider whether to **approve** or **deny** refill requests. Please check with your pharmacy to verify if your child's medication is there. Agape will ONLY call you if there is a **problem** with your request.

Late Cancellations/Missed Appointments:
Agape YBH, whenever possible, will notify you to remind you of your appointment. You are responsible for attending your scheduled appointment. A $50 fee will be added to the patient's account if the appointment is not attended or if the appointment is not canceled with a 24 hour notice. This fee is not covered by your insurance and is patient responsibility. Please note that Agape YBH cannot guarantee you will get a reminder notice in the event we have difficulty reaching you on the number designated. Please remember that this is a courtesy service that we offer and you are ultimately responsible for keeping your appointments.

Timeliness:
If you happen to run late, it is at our discretion whether or not the appointment will need to be rescheduled. It is imperative that you arrive on time in order to receive quality care.

Behavioral Health Emergency/Crisis:
In the event of a behavioral health emergency, please call 911, go to your nearest emergency room, or contact Parkridge Respond at 423-499-2300. Examples of an emergency include suicidal thoughts or plans, as well as thoughts of harming others.

Visit:
A parent or legal guardian must be present for initial evaluations and all medication management appointments for patients under the age of eighteen. If there are follow up appointments and someone else needs to bring the patient to the appointment, a legal guardian must complete an ROI, which then must be approved by the provider. If there is a custody agreement, we must have paperwork on file.

Legal Disputes:
Our providers are not trained in forensics. We are able to provide records at your request, but we do not attend any type of court cases to testify, etc.

Paperwork/Medical Records:
Please allow up to 1 week in order for us to complete medical records, school forms, letters, FMLA paperwork, etc. These can carry a charge of up to $50.00.

I have read and understand the above policies.

Patient Name:_____

Parent/Guardian Signature: _____ **Date:** _____

Patient Signature (if over 18): _____ **Date:**_____

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Authorization to Release Healthcare Information

Patient Name:_____ **Date of Birth:** _____

I authorize Agape Youth Behavioral Health to (choose your option): **RELEASE/OBTAIN/EXCHANGE** records with:

Name:_____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

This request and authorization applies to:

- ☐ Coordination of Care
- ☐ Continuity of Care
- ☐ Legal Purposes
- ☐ Other:_____

All information available may be released including physiological testing, lab testing, and any other reports, except as listed:_____

_____

Patient Name:_____**Parent/Guardian Signature:** _____

Date: _____**Relationship to Patient:**_____

Patient Signature (if over 18): _____ **Date:**_____

THIS CONSENT/AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING.
FORM MUST BE FILLED OUT COMPLETELY.

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Telehealth Consent Form

1. I hereby authorize Agape YBH to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition. The platform Agape uses is DoxyMe.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that the professionals can contact interactive sessions with video call; the patient MUST be present for the appointment.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I consent to treatment involving the use of electronic communications to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive telemedicine services, and I understand that existing confidentiality protections apply.

I acknowledge that while telemedicine can be used to provide improved access to medical care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission; equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

Patient Name:_____**Parent/Guardian Signature:** _____

Date: _____**Relationship to Patient:**_____

Patient Signature (if over 18): _____ **Date:**_____

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Fee Agreement and Debit/Credit Card Payment Authorization Form

We are committed to meeting your healthcare needs and keeping financial arrangements as simple and cost-effective as possible. Therefore, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment is expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge an extra $25 service fee for failure to pay at the time of service.
4. It is my responsibility to notify the practice at least 24 hours in advance if I am unable to keep my scheduled appointment. Failure to do this may result in a charge of up to $75. Insurance carriers DO NOT cover the cost of missed appointments and I understand that this charge would be my responsibility to pay.
5. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit. This includes maintaining coordination of benefits with my insurance company as necessary. Failure to provide updated and accurate information will require full payment from the guarantor on the account.
6. I agree to provide the above practice with my debit/credit card information to place on file.
7. I understand that my payment information will be maintained on file for future use by the practice. The applicable credit card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.
8. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
9. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits including amounts agreed as part of a payment plan, copayments, coinsurance (after application of insurance proceeds), amounts not covered by insurance, and/or fees charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
10. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance. If my account remains unpaid, then it will be turned over to collections and I will be responsible for all additional costs associated with debt collection including collection fees, attorney fees, and court costs.
11. I will not be provided with advance notice of payments authorized above for transactions up to $250 or another amount specified by me as _____ (must be at least $100). I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorizations for services already rendered cannot be canceled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Patient Name:_____ **Email:**_____

Billing Address Zip Code: _____**Phone Number:** _____

Responsible Party Name: _____

Authorized Signature:_____ **Date:**_____

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