University of Evansville

Mental Health Clinic and Emily M. Young Assessment Center

Today's date: _____

Youth Information Form

Full name: _____ Date of birth: _____ SSN: _____

Preferred nickname: _____ Gender at birth: _____ Gender identity:_____

Is the child currently in foster care? Yes No ***If applicable, please provide guardianship papers.**

If "yes", please provide the case manager's name, email, and phone:

_____

Home address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone number: _____

Religion/spiritual connection: _____ Race/ethnicity: _____ Language: _____

Primary Care Physician (name, phone, and where they practice):

_____

Would you sign a release to allow contact with the primary physician? Yes No

Referral Info:

How did you hear about us?

_____

Current concerns/symptoms to be addressed:

_____

How long have they experienced these concerns/symptoms?

_____

Please list any past psychological treatments, medications, tests, or hospitalizations:

_____

Family Information:

Names of child's legal guardians: 1) _____ 2) _____

Phone number: 1) _____ 2) _____

Relation: 1) _____ 2) _____

Highest education completed: 1) _____ 2) _____

Occupation: 1) _____ 2) _____

Parent marital status: Single Married Widowed Partnership Legally Separated Divorced

If Separated or Divorced, what was the child's age when this occurred? _____

If remarried, what was the child's age when this occurred? _____

Frequency of visitation with non-custodial parent: _____

Other people who care for your child for significant amounts of time: _____

Who is the person they feel most comfortable with sharing secrets, worries, or feelings? _____

Please list the members of their immediate family (include half or stepsiblings):

Name	**Relationship**	**Age**	**Medical & Psychological History** (Please include difficulties with attention span, learning, emotion regulation, and substance abuse.)	**Age of Diagnoses**	**Living?**	**Residing Together?**
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N
					Y N	Y N

Please check any of the following <u>stressful</u> events that apply to your child or your family:

☐ Relocations ☐ Deaths ☐ Illnesses

☐ Marital Problems ☐ Job Changes ☐ Legal Issues

☐ Experienced a traumatic event ☐ Witnessed a traumatic event ☐ Physical, sexual abuse, or neglect

☐ Social Services involvement ☐ Other: _____

<u>Pregnancy and Development:</u>

Birth weight: _____ lbs. _____ oz. Length of hospital stay: _____

Apgar scores, if known: / Require help to breathe? Yes No

Was the pregnancy typical? (describe) Yes No

_____

Any consumption of drugs, tobacco, or alcohol during pregnancy? Yes No

(This includes prescription drugs.)

_____

_____

Length of pregnancy: _____ Delivery method: Vaginal - Breech - Cesarean - Forceps Aided

Complications during labor or delivery? (describe) Yes No

_____

Newborn difficulties: None Cyanosis (Turned Blue) Stay in NICU or Special Care Nursery

Other: _____

Concerns about feeding as an infant? (describe) Yes No

_____

Did your child pass the newborn hearing screening? Yes No

Have there been any previous hearing tests? Yes No

Any significant family history of permanent childhood hearing loss? (describe) Yes No

_____

Indicate the age at which your child achieved the following:

Sat up without support: _____ Spoke first words: _____ Put 2-3 words together: _____

Crawled: _____ Spoke sentences: _____ Dressed self: _____

Walked: _____ Toilet trained: _____

Does your child have any problems with toileting? (describe) Yes No

_____

Does your child have any problems with going to or staying asleep? (describe) Yes No

_____

Describe your child's temperament/personality during development: (e.g., irritable, happy, easy-going, demanding)

As an infant: _____

As a toddler: _____

As a child: _____

Any concerns regarding your child's early development? (e.g., cognitive, speech and language, gross and fine motor skills) (describe) Yes No

_____

What hand does your child write with? Right Left Both (Ambidextrous)

Family history of left-handedness or mixed handedness? (list family members) Yes No

_____

Youth's Medical History:

	Circle One	Ages	Describe
Allergies	Y N		
Appetite/eating problems	Y N		
Asthma	Y N		
Clumsiness/poor motor skills	Y N		
Chronic constipation	Y N		
Chronic ear infections	Y N		
Headaches	Y N		
Hearing/ear problems	Y N		
Head injury	Y N		
Nightmares	Y N		
Persistent high fevers	Y N		
Physical disabilities	Y N		
Seizures	Y N		
Sleep apnea/snoring	Y N		
Surgeries	Y N		
Tics/twitching	Y N		
Vision/eye problems	Y N		
Alcohol use/abuse	Y N		
Illicit drug use/abuse	Y N		
Risky behaviors	Y N		

Additional medical and hospitalization history information: (please include age)

_____

_____

Are they currently being treated for anything? (describe) Yes No

_____

Current Prescribed and Over-the-Counter Medications:

Name of Medication	Dosage	Name of Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Difficulties following doctor's advice for medication or other treatments? (describe) Yes No

_____

Please list past, or current, counselors, psychologists, psychotherapists, and psychiatrists:

Age	Provider Name	Service (testing, treatment, medication)	Helpful?
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No
_____	_____	_____	Yes No

Would you sign a release to allow contact with these providers? Yes No

If testing has been completed, please have a copy of the results mailed or faxed to the office.

School History:

Name of current school: _____ Phone: _____

Grade: _____ Teacher: _____ Current letter grade: _____

Previous schools: (including pre-school) Dates:

_____ _____

_____ _____

_____ _____

Skipped grades: Yes No Which? _____ Reason: _____

Repeated grades: Yes No Which? _____ Reason: _____

Teacher reports problems with: (circle) Reading Spelling Math Writing

Social Skills Concentration Behavior Emotional Adjustment

School disciplinary actions: (circle) None Detention Suspension Expulsion

Attendance problems with current, or previous, schools: Yes No

Any special education, enrichment, resource services, or attend a gifted and talented program? Yes No

_____

	Circle One	**Ages**	**Describe**
Early Education Intervention	Y N		
Occupational Therapy	Y N		
Physical Therapy	Y N		
Speech Therapy	Y N		

If your child receives any special education services, please enclose a copy of your child's current Individual Education Plan (IEP) or have it sent by the school.

Favorite subjects: _____ Difficult subjects: _____

Effective disciplinary methods: _____

Personal strengths and talents: _____

Favorite activities: _____ Difficulties making friends? Yes No

Describe any problems your child may have with peers: (e.g., bullied, teased, poor social skills, no friends, aggressive)

_____

List any clubs, sports, or other organized activities: _____

_____

Please write any additional remarks you would like to review with us and how we may be able to help.

_____

_____

_____

_____

_____

Thank you for taking the time to complete this information form. Please make sure to drop it off at the reception desk when it is completed.

University of Evansville

Mental Health Clinic and Emily M. Young Assessment Center

UE Mental Health and Wellness Clinic
& Emily M. Young Assessment Center
University of Evansville
1931 Lincoln Ave. Suite A
Evansville, IN 47722
812-488-5640

NPI: 1023769213 (Katherine Hulsey, PA-C)
Tax ID: 35-0868074

Good Faith Estimate – Medication Management

Client Name: _____ Date of Notice: _____

Date of Birth: _____

Description of Services	CPT Code	Price	Price with Self-Pay Discount
Initial Outpatient **30 min. – 60 min.**	99203, 99204, 99205	$150.00 – $250.00	$90.00 - $150.00
Established Outpatient **20 min.**	99213	$115.00	$69.00
Established Outpatient **30 min.**	99214	$150.00	$90.00
Established Outpatient **40 min.**	99215	$200.00	$120.00

Diagnosis Code: TBD Location: On-site or Telehealth

I understand the following information as it pertains to the Good Faith Estimate:

1. This estimate is not a contract and does not require you to obtain the items or services listed above.
2. There may be additional items or services that are recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.
3. Information provided in the good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to the individual and that actual items, services, or charges may differ from the good faith estimate.
4. The client has the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate, as specified in **§ 149.620**. Instructions for how to initiate a patient-provider dispute resolution process will be provided by request at any time to the patient. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the individual.

Signature: Printed Name:

_____ _____ _____

Client, Parent/Guardian, Representative Date

University of Evansville

Mental Health Clinic and Emily M. Young Assessment Center

CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Client Name: _____ Client DOB: _____

CONSENT FOR TREATMENT

I consent to and authorize any healthcare professional who may be involved in my care at the UE Mental Health and Wellness Clinic and Emily M. Young Assessment Center to perform any evaluation procedures and/or therapy. I understand and acknowledge that within any of the treatment spaces that my care will be video and audio recorded. I understand that the recording will be used for internal educational purposes only, and that only those directly involved in training will have access to any identifying information about me.

FINANCIAL RESPONSIBILITY

Thank you for choosing the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center. Your understanding of our financial policy is important to our professional relationship. If at any time you need assistance, please contact us at 812-488-5640. We accept Cash, Check, and all major credit cards

ALL ACCOUNTS

I agree to be responsible for payment on the account. Payment is expected to be paid at time of service unless other arrangements are made in advance.

COMMUNICATIONS

I authorize the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center and any of its agents to contact me by telephone, at any of the numbers provided, including any wireless number for me and/or my spouse, which could result in charges to me/us. I acknowledge that my spouse or I may also be contacted by sending text messages, and/or emails, using any email address provided.

INSURANCE

UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center will file all insurance claims when applicable. **It is my responsibility to verify coverage with my insurance company. I understand that a quote of benefits from my insurance company is not a guarantee of payment.** It is my responsibility to understand my insurance coverage. Payment of deductibles, non-covered/denied services and co-payments are my responsibility. I also understand it is my responsibility to provide the insurance company with all requested information. If charges are denied due to my lack of response, the charges will become my sole responsibility. I will notify the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center immediately of any change in my insurance. Failure to notify of any changes will result in my responsibility for all charges that may occur.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my signature on all insurance claim forms and assign insurance payments to be made directly to the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center for services rendered.

RELEASE OF INFORMATION

I hereby authorize the release of information necessary to file claims with my insurance company. I also authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment. UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center cannot prevent re-disclosure of your information by the person or facility who receives your records under this authorization and the information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center from any and all liability resulting from a re-disclosure by the recipient. The authorization to release medical records will expire 180 days from close of file.

NOTICE OF PRIVACY PRACTICES ACKNOWLEGMENT

I have read, understand, and agree to the terms listed above. (Consent for treatment, Financial Responsibility and Release of Information) My signature also indicates that I have received a Notice of Privacy Practices from UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center.

Signature: Printed Name:

_____ _____ _____

Client, Parent/Guardian, Representative Date

University of Evansville

Mental Health Clinic and Emily M. Young Assessment Center

ATTENDANCE POLICY

Client Name: _____ DOB: _____ / _____ / _____

We are looking forward to working with you. Consistent attendance is required in order for clients to achieve maximal benefit from these services. Failure to maintain regular attendance can result in reduction of frequency of sessions or discharge from therapy altogether.

Clients are expected to attend all scheduled sessions. These sessions can be distinguished by the following:

Psychological Evaluations

Due to the demand and time of psychological testing, we may not reschedule if this appointment is a no show.

Ongoing Therapy

3 no shows within 6 months may result in termination of services.

If you are unable to keep your scheduled appointment, please contact our department as soon as possible. Another client may be able to utilize this spot.

- 812-488-5640 (Main Office)
- After hours- you can leave a message on our answering machine
- A late cancel is defined as cancelling within 4 hours of your scheduled appointment. Late cancels will be monitored and can result in a reduction of therapy sessions.

SUPERVISION OF YOUTH DURING VISIT (AGES 0-17)

Parents, guardians, or other adult designees bringing children (ages 0-17) to the clinic MUST remain on the property for the entire duration of the child's visit(s). If you would like to leave the lobby (while staying on the premises), you must check in at the reception window or with your provider and ensure we have updated contact information for you, should we need to get in touch with you during your visit. Please return to the lobby prior to the end of your child's visit. Your provider may require your presence in treatment at any time.

By signing below, I agree to maintain consistent attendance. I understand that therapy will be discontinued if I am unable to meet the above-listed requirements.

X _____ _____

Client (or Parent/Guardian/Representative) Signature Date