

Please read and review the following pages for an explanation of our office policies and keep them for your reference.

Please Initial:

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY

1. _____ I agree that I am responsible for payment of all charges for mental health services provided to me, including any copayments or deductibles. I understand that I am responsible for notification at the time of the visit of any benefit changes in my insurance plan. I further understand that I am responsible for any service provided to me that is not covered by my policy. I accept financial responsibility for the services provided to me by the Boys Town Behavioral Health Clinic.

NOTICE OF PRIVACY AND CLIENT RIGHTS

2. _____ I have received the Boys Town Notice of Privacy, which describes how confidential health information about the client may be used or disclosed and how to get access to this information. I have also received a copy of the Boys Town Behavioral Health Clinic Client Rights & Responsibilities.

CONSENT TO TREATMENT

3. _____ The Boys Town Behavioral Health Clinic works with children and their families to identify and treat such issues as depression, anxiety, school problems, and ADHD. The Behavioral Health Clinic offers specialized services, including behavioral and psychological assessments as well as counseling. I, knowing that the client has a condition requiring diagnosis and treatment, do hereby voluntarily consent to such treatment by the Behavioral Health Clinic staff, assistants, or designees as is, in their judgment, necessary. I further acknowledge that no guarantees have been made to me as to the results of treatment. I authorize you to provide reasonable and proper care by today's standards. If applicable, I have informed my treating provider of my mental health advance directives and have provided a copy for mental health decision-making that will become part of my treatment record.

CONTACT BY TELEPHONE and EMAIL

4. _____ I understand that by providing my landline or mobile number(s), I give my consent for the Behavioral Health Clinic, their agents, and their collection agents to contact me at these numbers, or at any number that is later acquired for me, and to leave live or pre-recorded messages, or voice or text messages, regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer. Providing a telephone (landline or mobile) number is not a condition of receiving services.

You may contact me by email:	Yes _____ No _____	Email address: _____
You may contact me by text:	Yes _____ No _____	Phone number: _____
You may contact me by phone:	Yes _____ No _____	
You may leave a message on my phone:	Yes _____ No _____	

PERMISSION TO FURNISH INFORMATION FROM RECORDS

(Please Initial one)

5. _____ - **YES** I understand that certain medical information regarding the client may need to be released by the Behavioral Health Clinic to third-party payers in order to obtain payment for the services provided. I hereby authorize and request the Boys Town Behavioral Health clinic staff to furnish medical information requested by the health insurance carrier or any other third-party payer. I authorize contact with my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy, and I authorize my insurance company or health plan administrator to release information to the Boys Town Behavioral Health Clinic.

_____ - **NO** I understand that even though I may have insurance that covers these services, I have selected to be financially responsible rather than submit to my insurance carrier.

COORDINATION OF CARE

6. _____ I understand that in order to provide the highest level of care, the Behavioral Health Clinic may request permission to discuss relevant aspects of care with other providers serving the client. Such providers may include but are not limited to: physicians, school personnel, and previous mental health providers. When contact with other providers is requested, a separate Authorization for the Release of Information will be completed and signed for each provider. If your clinician may communicate with the client's primary care provider (physician) about today's appointment, please sign the attached Authorization for the Release of Information Primary Care Provider form and return it with this form.

STATEMENT OF UNDERSTANDING

Signing below indicates that I have read or have had read to me the contents of this document and have received pertinent information regarding Office Policies, Client Rights & Responsibilities, and Notice of Privacy. I agree to abide by the stated terms and conditions of service provision. I agree that these provisions will remain in effect until I provide written revocation to the Behavioral Health Clinic. If I am signing for someone other than myself, I represent that I have legal authority to do so.

_____	_____	_____	_____
Print Client Name (If a minor, person authorized to sign for Client)	Signature of Client (If a minor, person authorized to sign for Client)	Relationship to Client	Date



Authorization to Release/Request Confidential Information To Primary Care Provider

Client Name: _____ Date of Birth: _____
 Released and/or Requested

- I do authorize Boys Town to contact/communicate with my child's / my Primary Care Provider.
- I do **NOT** authorize Boys Town to contact/communicate with my child's / my Primary Care Provider.

To/From (of Primary Care Provider/Clinic)

Name: _____
 Clinic: _____
 Address: _____
 Phone: _____ Fax: _____
email address is only required if this is the means of disclosure
 Email address: _____

Release Format: Paper Electronic

Release Method: (check all that apply): Email Mail Fax Pick up Verbal Other: _____

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing to Boys Town Records, at the address listed below. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless revoked, this authorization will expire in one (1) year from the date signed or on the following date/event whichever occurs sooner. Date _____ or Event _____
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information has the potential for re-disclosure, and may not be protected by federal confidentiality rules.
- Requests for copies of records may be subject to fees in accordance with applicable law.
- If I request release by unencrypted email or another unsecure method, I have been warned of and accept the security risks to the information associated with the unsecure transmission, and Boys Town is not responsible for breach notification or liable for disclosures that occur in transit.

_____ Print Client Name <small>(If a minor, person authorized to sign for Client)</small>	_____ Signature of Client <small>(If a minor, person authorized to sign for Client)</small>	_____ Relationship to Client	_____ Date
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Boys Town Records: 6460 Medical Center Street, Suite 140
Las Vegas, NV 89148

Phone Number: 702-888-1340
Fax Number: 702-888-1342

Risk of using email

Transmitting client information by email has a number of risks that the client or legal guardian (email recipient) should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous pages and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email may exist even after the sender of the recipients has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Email can be used as evidence in court.
- Email on shared email accounts can be viewed by more than the intended recipient.

Conditions for the use of email

Boys Town Behavioral Health will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, Boys Town Behavioral Health cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by Boys Town Behavioral Health's intentional misconduct. Thus, email recipients must consent to the use of email for treatment information. Consent to the use of email includes agreement with the following conditions:

- All emails to or from the email recipients concerning diagnosis or treatment will be printed out and made part of the client's records, and other individuals authorized to access the client records, such as staff and billing personnel, will have access to those emails.
- Boys Town Behavioral Health may forward emails internally to its staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling and/or as otherwise permitted by contract or applicable law. Boys Town Behavioral Health will not, however, forward emails to independent third parties without the client's/legal guardian's prior written consent, except as authorized or required by law.
- Although Boys Town Behavioral Health will endeavor to read and respond promptly to an email from an email recipient, Boys Town Behavioral Health cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, an email recipient shall not use email for medical emergencies or other time-sensitive matters.
- If an email recipient's email requires or invites a response from Boys Town Behavioral Health, and the email recipient has not received a response within a reasonable time period, it is the email recipient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The email recipient is responsible for informing Boys Town Behavioral Health of any types of information he/she does not want to be sent by email.
- The email recipient is responsible for protecting his/her own password or other means of access to email. Boys Town Behavioral Health is not liable for breaches of confidentiality caused by the client, his/her parent(s) or legal guardian(s), or any third party.
- It is the email recipient's responsibility to follow up and/or schedule an appointment if warranted.

Guidelines for email communication

To communicate by email, the email recipient shall:

- Inform Boys Town Behavioral Health of changes to his/her email address.
- Put the client's name and date of birth in the body of the email, not in the subject line.
- Withdraw consent only by written communication.
- Include the category of the communication in the email's subject line, for routing purposes (e.g., billing question).
- Review the email to make sure it is clear and that only relevant information is provided before sending to Boys Town Behavioral Health.
- Limit disclosure of treatment and sensitive information regarding client in the email.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding his/her computer password.



Behavioral Health Clinic Client Information Sheet

Client Information

Last Name:		First:		MI:	Birth Date:	
Address:				City:		State: Zip:
Home Phone:		Work Phone:		Marital Status: M D S W	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Is Client Currently a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician:				Referring Physician:		
Person to Notify in Case of Emergency (friend or relative not living with you):						
<i>Name</i>		<i>Relationship</i>			<i>Phone</i>	
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Decline to Answer						
Ethnicity: <input type="checkbox"/> Hispanic/Latino Origin <input type="checkbox"/> Not Hispanic/Latino Origin <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown						

Responsible Party (Legal Guardian)

Spouse/Other Parent

Last Name:		First:	M.I.:	Birth Date:	Last Name:		First:	M.I.:	Birth Date:			
Address:					Address:							
City:			State:	Zip:	City:			State:	Zip:			
Home Phone:		Work Phone:		Cell Phone:	Home Phone:		Work Phone:		Cell Phone:			
E-mail Address:				Relationship to Client:			E-mail Address:			Relationship to Client:		
Circle One:		Employed	Unemployed	Disabled	Retired	Circle One:		Employed	Unemployed	Disabled	Retired	
Employer Name:					Employer Name:							
Employer Address:				Phone:			Employer Address:				Phone:	

Primary Insurance Information

Secondary Insurance Information

Insurance Co. Name:				Insurance Co. Name:			
Insured's Name:				Insured's Name:			
Relationship to Client:				Relationship to Client:			
Policy #:		Group #:		Policy #:		Group #:	
Effective Date:		Insurance Phone #:		Effective Date:		Insurance Phone #:	

Your signature indicates that the above information is accurate and reflective of your current insurance information. You understand that you are responsible for any copayments or deductibles at each appointment. By signing below, you also understand that the benefit information that our office staff obtained is a courtesy and is NOT a guarantee that insurance will pay for the services provided. Further, you understand that you are responsible for any amount due that is not covered by your insurance provider, and you understand that the Clinic will bill you for any outstanding amounts owed. **You are responsible for reporting any insurance changes to the front desk staff at the time of your appointment.**

Name of responsible party

Signature of responsible party

Date



Behavioral Health Clinic E-mail Information Form

Risk of using e-mail

Transmitting client information by e-mail has a number of risks that the client or legal guardian (e-mail recipient) should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous pages and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender of the recipients has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.
- E-mail on shared e-mail accounts can be viewed by more than the intended recipient.

Conditions for the use of e-mail

Boys Town Behavioral Health will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Boys Town Behavioral Health cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Boys Town Behavioral Health's intentional misconduct. Thus, e-mail recipients must consent to the use of e-mail for treatment information. Consent to the use of e-mail includes agreement with the following conditions:

- All e-mails to or from the e-mail recipients concerning diagnosis or treatment will be printed out and made part of the client's records, and other individuals authorized to access the client records, such as staff and billing personnel, will have access to those e-mails.
- Boys Town Behavioral Health may forward e-mails internally to its staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling and/or as otherwise permitted by contract or applicable law. Boys Town Behavioral Health will not, however, forward e-mails to independent third parties without the client's/legal guardian's prior written consent, except as authorized or required by law.
- Although Boys Town Behavioral Health will endeavor to read and respond promptly to an e-mail from an e-mail recipient, Boys Town Behavioral Health cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, an e-mail recipient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If an e-mail recipient's e-mail requires or invites a response from Boys Town Behavioral Health, and the e-mail recipient has not received a response within a reasonable time period, it is the e-mail recipient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The e-mail recipient is responsible for informing Boys Town Behavioral Health of any types of information he/she does not want to be sent by e-mail.
- The e-mail recipient is responsible for protecting his/her own password or other means of access to e-mail. Boys Town Behavioral Health is not liable for breaches of confidentiality caused by the client, his/her parent(s) or legal guardian(s), or any third party.
- It is the e-mail recipient's responsibility to follow up and/or schedule an appointment if warranted.

3. Guidelines for e-mail communication

To communicate by e-mail, the e-mail recipient shall:

- Inform Boys Town Behavioral Health of changes to his/her e-mail address.
- Put the client's name and date of birth in the body of the e-mail, not in the subject line.
- Withdraw consent only by written communication to Boys Town Behavioral Health.



Behavioral Health Clinic E-mail Information Form

- Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that only relevant information is provided before sending to Boys Town Behavioral Health.
- Limit disclosure of treatment and sensitive information regarding client in the e-mail.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.

Acknowledgment and Agreement

I, whether for myself or on behalf of the below-identified client, acknowledge that I have read and fully understand the risks associated with the e-mail communication between Boys Town and me. I consent to the conditions outlined above. In addition, I agree to these guidelines, as well as any other conditions or guidelines that Boys Town Behavioral Health may impose to communicate with e-mail recipients by e-mail. Any questions I had were answered.

Print Client Name
(If a minor, person authorized to sign for Client)

Signature of Client
(if a minor, person authorized to sign for Client)

Relationship to Client

Date

Providing a valid email address below authorizes e-mail communication between the Client or Legal Guardian listed above and the client's therapist.

All other authorizations regarding e-mail communication with interested third parties require completion of Behavioral Health Clinic Authorization to Release Confidential Information.

Name of Client: _____ Date of Birth _____
Name of email recipient: _____
Email Address: _____



Behavioral Health Clinic Pretreatment Questionnaire

Client Name: _____ DOB: _____ Date: _____ M F

Race: American Indian or Alaska Native Asian Black or African American White
 Native Hawaiian or Other Pacific Islander Other Decline to Answer

Ethnicity: Hispanic or Latino Origin Not Hispanic or Latino Origin Decline to answer Unknown

Form completed by: Self Parent Other

Referred by: Physician Employer Relative Friend Website
 Other: _____
Relationship to client

Primary concern(s) for which treatment is sought: _____

1. Please rate your child on each of the areas below AND whether it has been a problem during the last month:

	Extremely Poor			OK			Extremely Well			Is this a problem?	
	1	2	3	4	5	6	7	Yes	No		
Getting along with family	1	2	3	4	5	6	7	Yes	No		
Getting along with other peers/children outside of the home	1	2	3	4	5	6	7	Yes	No		
Getting along with other adults outside of the home	1	2	3	4	5	6	7	Yes	No		
Performance at school/work	1	2	3	4	5	6	7	Yes	No		

2. Please rate your child on each of the areas below AND whether it has been a problem during the last month:

	Never			Sometimes			Always			Is this a problem?	
	1	2	3	4	5	6	7	Yes	No		
Overactive, acts without thinking	1	2	3	4	5	6	7	Yes	No		
Sad, unhappy, down, or depressed	1	2	3	4	5	6	7	Yes	No		
Worried, nervous, and/or anxious	1	2	3	4	5	6	7	Yes	No		
Difficulties with school (academics and/or behavior)	1	2	3	4	5	6	7	Yes	No		
Sleeping problems	1	2	3	4	5	6	7	Yes	No		
Problems with temper, having a 'short fuse'	1	2	3	4	5	6	7	Yes	No		
Difficulty tolerating frustration/change	1	2	3	4	5	6	7	Yes	No		
Problems with peers	1	2	3	4	5	6	7	Yes	No		
Other: _____	1	2	3	4	5	6	7	Yes	No		
Other: _____	1	2	3	4	5	6	7	Yes	No		

Clinician Use:		Int		Ext		Comb		Oth
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Behavioral Health Clinic
Pretreatment Questionnaire

Individuals living with child/youth:

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

Divorced/Separated/Not Living Together: No [] Yes [] If yes, please note above who (adults and children) lives with your child in each residence. Also, please describe current parenting schedule/time spent in each household: _____

Educational history:

Current school: _____ Current grade: _____
Special education placement? No [] Yes [] If yes, in what area? _____
Has the school performed psychological testing? No [] Yes [] If yes, when? _____
Is there an IEP (Individual Educational Plan)? No [] Yes [] Don't know [] _____

Child's interests/activities: _____

What are your child's strengths? _____

Previous mental health treatment:

No [] Yes [] If yes, please detail below:
Mo/Yr _____ Provider _____ Treatment _____ Outcome _____
Mo/Yr _____ Provider _____ Treatment _____ Outcome _____

Current legal concerns:

No [] Yes [] If yes, please explain: _____

Past History of abuse:

No [] Yes [] If yes, please explain: _____

Religious/spiritual affiliation(s): _____

None [] Prefer not to answer []

Developmental history:

Complications at birth or in early childhood? No [] Yes [] If yes, please explain: _____

Medical diagnoses and conditions:

None [] Yes [] List: _____

Significant operations/invasive procedures

None [] Yes [] List: _____

Serious injuries/chronic illnesses/hospitalizations:

None [] Yes [] List: _____



Behavioral Health Clinic
Pretreatment Questionnaire

Last visit to doctor/well-check date: Doctor's name:

Allergies: None Yes List:

Immunizations current Yes No If no, please explain

Medications (prescribed and over-the-counter): None
Medication Dosage Prescribing Physician Started
Date of last medication check.

Adverse drug reactions: None Other

Substance use:

Alcohol Use: None Suspected Known to use currently Recovering
Type: Amount: How often?

Drug Use: None Suspected Known to use currently Recovering
Type: Amount: How often?

Client Name (if not a minor) Signature of Client Date

Legal Guardian Name (Print) Relationship (e.g., mother, father, etc.) Signature of Legal Guardian Date