Patient Service Agreement and Consents
Hospital Inpatient, Outpatient, Physician Services and
Boys Town Behavioral Health Clinics

1. **CONSENT.** The undersigned patient/client, or their legally authorized representative ("Patient"). acknowledges that they have a condition requiring certain medical diagnosis, behavioral health diagnosis and medical, behavioral health or surgical treatment ("Services"). Patient voluntarily consents to such Services, including routine hospital, outpatient care or behavioral health services, as is judged necessary and appropriate by Father Flanagan's Boys' Home a/k/a Boys Town, also d/b/a Boys Town National Research Hospital, its clinics, affiliates, institutes, officers, physicians, technicians, nurses, medical staff, medical professionals, psychologists, post-doctoral fellows, assistants, representatives, contractors, agents, designees, volunteers, and employees (collectively, "Boys Town"). Boys Town makes no warranty or guaranty as to the manner, methods, and results of the Medical Services. Medical Services will be rendered according to Boys Town's policies and procedures and in accordance with generally accepted medical practices. Patient understands that they have the right to refuse Services and that Patient does not consent to any specific Service by signing this consent. Boys Town will ask the Patient to sign additional forms acknowledging informed consent to specific recommended Medical Services.

2. **ASSIGNMENT OF BENEFITS.** Patient assigns and directs all healthcare insurance, coverage, policy, plans, and other related benefits (collectively, "Healthcare Benefits") be paid to Boys Town so that the Healthcare Benefits may reimburse Boys Town for some or all of the Medical Services rendered. Healthcare Benefits include, but are not limited to, all benefits for all medical and hospitalization insurance, accident insurance, disability or loss-of-time insurance, Medicaid, and Tricare, benefits payable by alternative delivery systems such as HMOs and PPOs or arising from worker’s compensation or occupation disease claims; and proceeds to which Patient is entitled. Patient agrees that Boys Town may directly receive Healthcare Benefit payments and discharge the payor to the extent of such payments made. Any credit balance may be applied to any other account owed by Patient, if applicable. This assignment may not be revoked as to services provided during this hospitalization or course of diagnosis and treatment. Patient certifies that information they have provided to Boys Town is true, accurate, and complete.

3. **FINANCIAL AGREEMENT.** Patient remains financially responsible for the full payment of Services rendered by Boys Town, except to the extent said services are covered by Patient's Healthcare Benefits. Patient understands that they are responsible for payment of any amounts not covered by their Healthcare Benefits. Patient also understands that it is their responsibility to obtain any prior approvals required by their Healthcare Benefit provider and to take any other steps to qualify for benefit coverage.

4. **RELEASE OF INFORMATION TO THIRD PARTY PAYORS.** Patient understands and consents to Boys Town's disclosure of their medical record and protected health information to any person or entity which may be responsible for payment or reimbursement of all or any portion of the charges incurred in providing Services including, but not limited to, any private insurance carrier, Healthcare Benefit provider, Medicare, Medicaid, Medicaid, and Tricare insurer, and other third-party payor. Patient also understands and consents to Boys Town's release at any time of the medical records from this hospitalization, Medical Services, or other services to any physicians or other health care professionals (and their staff) that may require protected health information in connection with Patient's current or subsequent health care.

5. **MEDICARE PATIENTS ONLY – ASSIGNMENT AND CERTIFICATION.** If applicable, Patient also assigns and directs all Medicare benefits be paid to Boys Town so that Medicare benefits may also reimburse Boys Town for some or all of the Medical Services rendered. Until revoked, this statement applies to all occasions in which Services are rendered by Boys Town to the Patient.

6. **MEDIGAP PATIENTS ONLY – ASSIGNMENT OF MEDIGAP BENEFITS.** If applicable, Patient also assigns and directs all Medigap benefits be paid to Boys Town so that the Medigap benefits may also reimburse Boys Town for some or all of the Medical Services rendered. Until revoked, this statement applies to all occasions in which Medical Services are rendered by Boys Town to the Patient.
7. **PERSONAL VALUABLES.** Boys Town is not responsible for any of Patient's lost or stolen personal property or valuables during Patient's appointments or hospitalization. Patient understands that personal property and valuables (for example, money, cell phones, mobile devices, and jewelry) should be entrusted to a family member or friend or left at home when they are not able to remain with the belongings. Patient unconditionally releases and holds Boys Town harmless from all responsibility for any personal possessions, property, or valuables brought to any Boys Town facility.

8. **NOTICE OF PRIVACY PRACTICES.** Patient acknowledges that they have been provided a copy of Boys Town's Notice of Privacy Practices.  
*Please circle yes or no. YES NO*

9. **PATIENT/CLIENT RIGHTS AND RESPONSIBILITIES.** Patient acknowledges that they have been provided a copy of the Patient or Clients Rights and Responsibilities document.  
*Please circle yes or no. YES NO*

10. **RESEARCH STUDIES.** Patient is ok with researchers conducting studies at Boys Town contacting them in regard to experimental research studies that may be of interest to the Patient.  
*Please circle yes or no. YES NO*

11. **HEALTH INFORMATION EXCHANGE (HIE).** Boys Town is a participating provider in Health Information Exchanges, which allows healthcare providers to appropriately access and securely share a patient's vital medical information electronically with their other healthcare providers, improving speed, quality, safety and cost of patient care. Patient understands that their health information will be included in Health Information Exchanges unless they opt out.  
*Patient has received information on how to opt out of the HIEs which Boys Town currently partners with.*

12. **CONTACT BY TELEPHONE.** By providing us with your landline, mobile, or cellular phone number(s), you give your consent for us, our agents, and our collection agents, to contact you at these numbers, or, at any number that is later acquired for you, 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 auto-dialer. Providing us a telephone (landline or mobile) number is not a condition of receiving our services.

13. **AUTHORIZATION TO LEAVE PROTECTED HEALTH INFORMATION (PHI) ON PERSONAL VOICEMAILS.** By providing a landline, mobile, or cellular phone number(s), the Patient gives consent for Boys Town to contact the Patient at these numbers, or, at any number that is later acquired for the Patient. The Patient consents for Boys Town to communicate live with the Patient, leave pre-recorded messages or voice messages regarding treatment. The Patient understands that messages left on a voicemail that does not identify the patient's name or phone number will only contain the caller's name, the provider's office name and the call back number. The Patient understands that messages left on a voicemail for a shared phone number may be heard by someone else at that shared number. For greater efficiency, calls may be delivered by an auto-dialer. The Patient agrees by signing the consent that it is valid unless properly revoked.

*I, the Patient, fully acknowledge the risks involved with leaving protected health information (PHI) on voicemails. I agree to waive my privacy rights in this area and allow my physician or other staff to perform this service in an effort to expedite communications regarding results of tests. PHI messaging would include lab results within normal limits; radiology results within normal limits; changes to medication, care or treatment for an existing condition or upcoming appointments.  (Please circle yes or no. YES NO)*

14. **VIDEO RECORDING (BEHAVIORAL HEALTH CLINICS ONLY).** I understand that appointments may be videotaped for supervision purposes. This is to ensure the patient is being provided quality care. The therapist will request a separate consent form be completed if they would like to use the videotaped appointment for reasons other than supervision.

15. **PLAYROOM AND TEEN ROOM (BEHAVIORAL HEALTH CLINICS ONLY).** The Playroom and Teen Room are provided for convenience only and are monitored by a live video feed. Children and their parents/guardians shall use the Playroom or Teen Room at their own risk. Boys Town shall assume no liability or responsibility for any damage, loss, injury or any liability of any kind resulting from anyone's use of the Playroom or Teen Room.
I certify that I have read or had read to me the contents of this document. I understand and voluntarily accept its terms. I have had the opportunity to ask questions and any questions I asked have been answered in a satisfactory manner. If I am signing for someone else, I represent that I have legal authority to do so.

Patient Name (PRINT) ____________________________________________

Legally Authorized Representative Name (PRINT) ____________________________________________

Signature ____________________________________________
(Patient or Legally Authorized Representative)

Date ____________________________ Time ____________________________

Relationship to Patient: ____________________________________________

(Witness to Verbal Consent) ____________________________________________ (Witness to Verbal Consent)

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

FOR OFFICE USE ONLY: DOCUMENTATION OF GOOD FAITH EFFORT/NOTICE OF PRIVACY PRACTICES
- Patient/parent/legal guardian had already received the Notice of Privacy Practices at one of the Boys Town locations.
- Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.
- Patient/parent/legal guardian was unable to acknowledge receipt of the Notice of Privacy Practices at one of the Boys Town locations.
- The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.
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  Signature of Client  Relationship to Client  Date
(If a minor, person authorized to sign for Client) (If a minor, person authorized to sign for Client)

Boys Town Records: 6460 Medical Center Street, Suite 140
Las Vegas, NV 89148

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

Page 1 of 2
11/2018
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.
Authorization to Release/Request Confidential Information

Client Name: ___________________________ Date of Birth: ___________________________

I request protected health information (PHI) for the above named client from Behavioral Health to be:

☐ Released and/or ☐ Requested

Send Information to/from:

Name:
Agency (if applicable):
Address: ___________________________ Phone: ___________________________
Fax: ___________________________

Email address: ___________________________

This information is requested for the purpose of:

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Legal Action/Proceedings
☐ Personal/Request of Service Recipient ☐ Treatment Coordination/Progress
☐ Other (Please Specify) ☐ *Substance Use

*(Chemical Use Program Only) ___________________________ *Signature of minor (minors must sign for release of substance abuse records)

NOTICE TO RECIPIENTS: You are prohibited from disclosing the information to any other party and are required to destroy the information after the stated need has been fulfilled. This information has been disclosed to you from records, which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Information to be released: ☐ MDT/IEP ☐ Psychological Evaluation/Testing ☐ Treatment Summaries
☐ Other

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:

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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

Boys Town Records: 6460 Medical Center Street, Suite 140 Las Vegas, NV 89148
Phone Number: 702-888-1340
Fax Number: 702-888-1342
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- 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.
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- 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.
# Client Information Sheet

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First:</th>
<th>MI:</th>
<th>Birth Date:</th>
</tr>
</thead>
</table>

| Address: | City: | State: | Zip: |

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Work Phone:</th>
<th>Marital Status:</th>
<th>Gender:</th>
<th>Is Client Currently a Student?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M D S W</td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

| Primary Care Physician: | Referring Physician: |

**Person to Notify in Case of Emergency (friend or relative not living with you):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
</table>

**Race:**

- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Decline to Answer

**Ethnicity:**

- Hispanic/Latino Origin
- Not Hispanic/Latino Origin
- Decline to Answer
- Unknown

## Responsible Party (Legal Guardian) vs. Spouse/ Other Parent

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First:</th>
<th>M.I.:</th>
<th>Birth Date:</th>
<th>Last Name:</th>
<th>First:</th>
<th>M.I.:</th>
<th>Birth Date:</th>
</tr>
</thead>
</table>

| 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: |

<table>
<thead>
<tr>
<th>Circle One:</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Disabled</th>
<th>Retired</th>
<th>Circle One:</th>
<th>Employed</th>
<th>Unemployed</th>
<th>Disabled</th>
<th>Retired</th>
</tr>
</thead>
</table>

| Employer Name: | | Employer Name: | |

| Employer Address: | Phone: | Employer Address: | Phone: |

## Primary Insurance Information vs. 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.**
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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.

<table>
<thead>
<tr>
<th>Print Client Name</th>
<th>Signature of Client</th>
<th>Relationship to Client</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If a minor, person authorized to sign for Client)</td>
<td>(If a minor, person authorized to sign for Client)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ___________________________
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 ☐ __________________________ Relationship to client

Referred by: Physician ☐ Employer ☐ Relative ☐ Friend ☐ Website ☐ Other: __________________________

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:

<table>
<thead>
<tr>
<th>Area</th>
<th>Extremely Poor</th>
<th>OK</th>
<th>Extremely Well</th>
<th>Is this a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting along with family</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Getting along with other peers/children outside of the home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Getting along with other adults outside of the home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Performance at school/work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
<th>Is this a problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overactive, acts without thinking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Sad, unhappy, down, or depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Worried, nervous, and/or anxious</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Difficulties with school (academics and/or behavior)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Sleeping problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Problems with temper, having a ‘short fuse’</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Difficulty tolerating frustration/change</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Problems with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Other:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Other: 1 2 3 4 5 6 7 Yes No

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

Individuals living with child/youth:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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: ____________________________

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:

<table>
<thead>
<tr>
<th>Mo/Yr</th>
<th>Provider</th>
<th>Treatment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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: ____________________________
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):

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Prescribing Physician</th>
<th>Started</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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 __________