BOYS TOWN
Saving Children Healing Families

Client Name _____

Behavioral Health Clinic Agreement and Consent for Services

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
_____	_____	_____	_____

BOYS TOWN

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: ☐ M ☐ F Is Client Currently a Student? ☐ Yes ☐ No

Primary Care Physician: Referring Physician:

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

Name *Relationship* *Phone*

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)

Last Name: First: M.I.: Birth Date:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

E-mail Address: Relationship to Client:

Circle One: Employed Unemployed Disabled Retired

Employer Name:

Employer Address: Phone:

Spouse/Other Parent

Last Name: First: M.I.: Birth Date:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

E-mail Address: Relationship to Client:

Circle One: Employed Unemployed Disabled Retired

Employer Name:

Employer Address: Phone:

Primary Insurance Information

Insurance Co. Name:

Insured's Name:

Relationship to Client:

Policy #: Group #:

Effective Date: Insurance Phone #:

Secondary Insurance Information

Insurance Co. Name:

Insured's Name:

Relationship to Client:

Policy #: Group #:

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 _____

BOYS TOWN

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.

Email Address: _____

BOYS TOWN

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 ☐ _____
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:

	Extremely Poor			OK			Extremely Well	Is this a problem?	
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?	
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

BOYS TOWN

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: _____

BOYS TOWN

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 _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
Medication _____ Dosage _____ Prescribing Physician _____ Started _____
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

BOYS TOWN

Behavioral Health Clinic
Developmental History Form

Developmental History

Was the birth at full term? Yes No

If no, how many weeks of gestation? _____ weeks

Birth weight: _____ pounds _____ ounces

Was there a C-section? Yes No If yes, was it planned? Yes No

Did your child spend time in the NICU? Yes No If yes, how long?_____

Complications: _____

Was there smoking/alcohol/substance use during pregnancy? Yes No

If yes, list _____

Did your child demonstrate excessive crying or colic? Yes No

Were there feeding or eating difficulties? Yes No Are they current? Yes No

Were there sleeping difficulties? Yes No Are they current? Yes No

What time does child currently fall asleep: _____ Wake up time:_____

Is the bedtime routine a struggle? Yes No

Does your child wake up frequently during the night? Yes No

Does your child wet the bed more than once per week? Yes No

Developmental Milestones

Speech: On time Delayed By low long? _____

Walking: On time Delayed By low long? _____

Toilet training: On time Delayed When was it achieved?_____

Has your child attended Speech therapy? Yes No When_____

Has your child attended Occupational therapy? Yes No When_____

Behavior

What percent of the time does your child follow directions the first time they are given?

At home: _____ % At school: _____ %

Comments: _____

How is misbehavior managed? _____

Is it effective? Yes No

Friendships

Describe your child's relationships with peers/friends: _____

School

Typical grades for your child _____

Favorite subject_____ Least favorite subject_____

Has your child repeated a grade? Yes No If yes, what grade?_____

Has your child been suspended? Yes No If yes, how many times?_____

Has your child been expelled? Yes No If yes, what grade(s)?_____

BOYS TOWN

Behavioral Health Clinic

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 (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: 1655 Palm Beach Lakes Boulevard, Suite 102
West Palm Beach, FL 33401

Phone Number: 561-612-6056
Fax Number: 561-612-6097