Welcome to Complete Children's Health Psychology Services!

Our Psychology Clinic is a specialty clinic staffed by Pediatric Psychologists. Services are provided to children, adolescents, and their families for developmental, behavioral, emotional, social, and school problems. Our goal is to collaborate with your child's pediatrician to provide a comprehensive assessment and treatment for a wide range of behavioral and emotional concerns. If you need to reach the clinic, please contact us at (402) 465-5600.

Appointment Information

An initial appointment for the clinic typically takes 60-90 minutes. The child and at least one of his/her parent(s)/legal guardian must attend the first appointment. We will discuss the child's and family's history as well as the presenting concerns. Limits of confidentiality and additional clinic procedures will be discussed at the initial session.

After an initial appointment, additional therapy appointments may be scheduled. Therapy appointments typically last 45 -60 minutes. Shorter sessions may be scheduled as needed. Testing and evaluation sessions, if needed, are also conducted after the initial appointment and will vary in length depending on the circumstance.

Cancellation Policy

If you cancel your initial appointment less than 24 hours or no show, you may not be able to reschedule. For returning appointments we request that you contact us at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule the appointment. Fewer than 24 hours notice on 2 or more occasions will require us to discuss alternative plans for your child's behavioral health needs. There will be a $25 fee for any missed appointment or any appointment cancelled less than 24 hours prior to the scheduled appointment time. This fee is considered non-billable by insurance companies and you will be responsible for the charge.

Insurance Information

Please **bring your insurance card with you to every appointment**, and promptly inform us of any changes in your insurance coverage.

While most insurance companies reimburse for mental health or behavioral health services; coverage for mental health services is determine by your individual policy. Complete Children's Health is not provided with information about your specific policy benefits and coverage until after a claim has been filed. It is the family's responsibility to understand the benefits of their individual insurance policy. **We recommend that you review your coverage for mental health services by calling the number listed on the back of your insurance card. Psychology appointments are not always covered the same way as a Medical Service. When contacting your insurance carrier, you will want to ask if the specific Psychologist your child will be seeing is in-network or out-of-network and how benefits are paid accordingly. Typical codes that we bill are 90791, 90834, 90837, 90847, 96101 and ask if there are any diagnoses excluded from your specific plan.**

Many companies require pre-authorization. Complete Children's Health will call your insurance to verify if preauthorization is needed and determine the appropriate copay due at each appointment. We attempt to contact families as soon as possible when we are aware that an individual policy does not provide benefits for mental health services or out-of-network services.

As part of our agreement with insurance carriers, we are required to collect copays at the time of service. If the services will not be covered by your child's insurance plan, then you are responsible for full payment the day of the appointment. The patient's balance for appointments is expected 30 days after the date of the appointment. The patient (or the patient's parent, legal guardian, or authorized representative) retains responsibility for payment of all fees, whether or not they are covered by insurance. For more detailed information about fees and insurance, please review our Credit and Collection Policies brochure or contact our Billing Department.

Please complete the following information and bring it to your child's first appointment with_______________.

Thank you.

If you forget to bring this *completed* form to the first appointment, a receptionist will require you complete the form before your child will be seen.

* State-sponsored insurance plans require this information be included in the medical record.

PATIENT INFORMATION

* Patient's Name: ______________________________ Home Address: ______________________________

Nickname: __________________________________ ____

* Date of Birth ____/____/____ Age __________ Phone: ____________________________________

Gender: Male Female Cell Phone/Work Phone _______________________

*Race (circle all that apply): African-American Asian-American Native American White/Caucasian Other: ____________

*Ethnicity (circle one): Hispanic Not Hispanic

REFERRAL INFORMATION

* Patient's Physician ___________________________ * Who referred patient to the clinic ______________________

Reason for Referral / Primary Concerns:____

FAMILY INFORMATION / PATIENT BACKGROUND INFORMATION

Mother's Name ________________________________ Father's Name __________________________

(circle one) Biological Adoptive Step Foster/Guardian (circle one) Biological Adoptive Step Foster/Guardian

Age ________ Occupation ______________________ Age ________ Occupation _____________________

Employer ____________________________________ Employer ___________________________________

Work Schedule _______________________________ Work Schedule ______________________________

Phone # to be reached __________________________ Phone # to be reached__________________________

* Biological parents are: Married ________ Divorced ________ Separated ________ Never Married

Date Date Date

Who has Physical Custody? _______________________________________ N/A

* Who has Legal Custody? Joint Custody/Both parents One parent ____________ Ward of State

* If Ward of State: Caseworker____________________ Phone number:_________________

* Patient resides with: Mother Father

Biological Adoptive Foster Step Other Biological Adoptive Foster Step Other

* Other Members of the Household (for example, siblings, step-siblings, foster children):

Name	**Age**	**Sex**	**Relationship to patient**

* Other Regularly Involved Adults (for example, grandparents, non-custodial parents/step-parents):

Name	**How often**	**Relationship to patient**

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* Any problems/stressors in the family in the last year? (for example, death in the family, move, parental/marital conflict, financial stressors, accidents/traumatic events) ____

SCHOOL INFORMATION

Child attends daycare? NO YES (name of daycare/child care provider) _________________________________

* Child attends school? NO YES (grade) ___________ (If summer, what grade will child be entering).

* School ______________________________________ __ Teacher's Name ______________________________

Child's current grades are: ________________________ Grades last semester were: ____________________

Has the patient ever been suspended or expelled? NO YES (when) __________________________________

Has the patient ever been retained in a grade? NO YES (when)______________________________________

Have you had special conferences or extra meetings with teachers or school administrators for your child's behavior or learning problems? NO YES (when) __________________

* Has the patient ever had an IEP, 504 Plan, or other Special Education Services? NO YES
(for example, learning disability, behavioral/emotional disorder class, speech/language services, resource room)

DEVELOPMENTAL INFORMATION

* Were there any problems with pregnancy or delivery? NO YES

* Were there any concerns with drug/alcohol use or cigarette use during pregnancy? NO YES

* Was the child born prior to 36-40 weeks gestation? NO YES If yes, list gestation at birth:_________________

* What is your impression of your child's health/development during their first year of life? GOOD FAIR POOR

* Note the month in which your child achieved the following activities:
Sat alone ______ Crawled ______ Walked ______ Fed Self ______ Spoke Words ______ Toilet Trained _____
(*Normal development*: Sit 6-8 months; Crawl 9 mo; Walk 12-18 mo; Feed 10-12 mo; Speak 10 mo; Toilet 24-36 mo)

MEDICAL INFORMATION

Any problems with the patient's vision? NORMAL ABNORMAL CORRECTED

Any problems with the patient's hearing? NORMAL ABNORMAL CORRECTED

Any problems with the patient's speech? NORMAL ABNORMAL CORRECTED

* Circle all conditions in which this child has had or currently has:

ALLERGIES ASTHMA CANCER DIABETES GENETIC CONDITION SEIZURES

* Other medical conditions/health concerns: ____

* Specialists/health care providers that are currently involved with the patient's care (e.g., Allergist, Speech Therapist, etc.)

____

Any hospitalizations? NO YES If yes, add dates and explanation_________________________________

Any surgeries? NO YES If yes, add dates and explanation______________________________________

Any history of head trauma/injury or loss of consciousness? NO YES _______________________________

Current Medications

* Medication Name	* Dosage	* Purpose	* Date Started	* Prescribed By

* Any over the counter medications routinely taken?____

* Any allergies to medication? ____

MENTAL HEALTH HISTORY

* Has the patient ever received medications for behavioral/emotional concerns? NO YES

If yes:

Medication Name	Dosage	Purpose	Date Started	Prescribed By

* Has the patient ever received counseling or psychotherapy for behavioral/emotional concerns? NO YES

If yes:

* Provider Name	* Treatment Dates	* Was treatment effective

* Has a parent or other family members received medication, counseling, or psychotherapy? NO YES

* Has anyone in the patient's family (including parents, siblings, grandparents, uncles, aunts) ever been diagnosed with any of the following problems? (circle all that apply)

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) LEARNING PROBLEMS DEPRESSION

ANXIETY MANIC DEPRESSION / BIPOLAR ALCOHOL / DRUG ABUSE SCHIZOPHRENIA

OBSESSIVE-COMPULSIVE DISORDER (OCD) NONE OTHER_____________________________

*Does anyone in the immediate family/household have concerns related to substance abuse?________________________

LEGAL ISSUES/VICTIM ISSUES

* Has the patient had any law violations or contact with law enforcement? NO YES __________________________________

* Do parents or other family members have legal violations? NO YES ____

* Has the child experienced neglect, physical or sexual abuse, or witnessed domestic violence? NO YES

* Has Child Protective Services (CPS) ever been involved with the family or patient? NO YES ___________________________

Substance Use/Abuse by patient (12 years old and older)? Circle the one that best describes the patient's use.

* Caffeine: daily weekly occasionally once or twice never

* Nicotine/Cigarettes: daily weekly occasionally once or twice never

* Alcohol: daily weekly occasionally once or twice never

* Other drugs (marijuana, cocaine, meth, etc): daily weekly occasionally once or twice never

* Misuse of prescription or over the counter drugs: daily weekly occasionally once or twice never

SLEEP INFORMATION

Does your child have a bedtime routine? NO YES

What time does your child typically go to bed? _______ What time does he/she typically fall asleep?_______

What time does he/she wake up in the morning?_______ Does the patient snore loudly? NO YES

Does the patient typically wake up in the middle of the night? NO YES

Does the patient typically take a nap each day? NO YES (how long) _______________

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BEHAVIORAL HEALTH INFORMATION

* Describe the best things about your child?____

* List the clubs/groups and favorite activities of your child: ____

____

* Patient's work or volunteer experiences: ____

* Community resources (e.g., YMCA, Food Bank, Region V, etc) and church activities: _________________________________

____

* Religious preference: ___________________________

Which of the following *have recently been* or *currently are* problems with your child?

	Never	Some	Often	Always		Never	Some	Often	Always
Won't mind	____	____	____	_____	Suicidal thoughts	____	____	____	_____
Too active	____	____	____	_____	Nervous	____	____	____	_____
Anger/Temper	____	____	____	_____	Cries a lot	____	____	____	_____
Clumsy	____	____	____	_____	Harms self	____	____	____	_____
Destructive	____	____	____	_____	Very Shy	____	____	____	_____
Easily upset	____	____	____	_____	Clings to parent(s)	____	____	____	_____
Toileting problems	____	____	____	_____	Nightmares	____	____	____	_____
Impulsive	____	____	____	_____	Aggressive to others	____	____	____	_____

* What concerns you most about your child? ____

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Please provide any other information you would like to discuss during your child's upcoming appointment. ________________

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