HUMAN DYNAMICS & DIAGNOSTICS

NEW PATIENT FORMS - YOUTH

PATIENT INFORMATION

Date_____ Legal Name_____ Preferred Name_____

Date of Birth____/____/____ S.S.#_____ Gender_____ Sex: ☐Male ☐Female

Race/Ethnicity: ☐Native American ☐Latino ☐Asian ☐Pacific ☐Black ☐White ☐Other_____

Address_____ City_____ State_____ Zip_____

Phone (main)_____ Phone (other)_____ Email_____

Emergency Contact_____ Relationship_____ Phone_____

Is the patient covered by any of the following? (please check): ☐Medicare ☐Medicaid ☐Medicaid YES Program

GUARDIANSHIP (Write "SAME" for info that is the same as above)

Note: Please provide Human Dynamics & Diagnostics with legal documentation of custody/guardianship if applicable.

Primary Guardian(s)_____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

Other Guardian(s)_____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

RESPONSIBLE PARTY FOR AUTHORIZATION OF MEDICAL TREATMENT (Write "SAME" for info that is the same as above)

Name_____ S.S. #_____ Date of Birth____/____/____

Address_____ City_____ State_____ Zip_____

Employed By_____ Work Phone_____

Work Address_____ City_____ State_____ Zip_____

PRIMARY INSURANCE (Write "SAME" for info that is the same as above)

Insured Name_____ S.S. #_____ Date of Birth____/____/____

Relationship to patient_____ Phone_____ Sex: ☐Male ☐Female

Address_____ City_____ State_____ Zip_____

Insurance Company_____ I.D.#_____ Group #_____

SECONDARY INSURANCE (Write "SAME" for info that is the same as above)

Insured Name_____ S.S. #_____ Date of Birth____/____/____

Relationship to patient_____ Phone_____ Sex: ☐Male ☐Female

Address_____ City_____ State_____ Zip_____

Insurance Company_____ I.D.#_____ Group #_____

HUMAN DYNAMICS & DIAGNOSTICS

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your treatment.

- We bill most major insurance companies as a courtesy and at no cost to patients. You are fully responsible for payment of services rendered. For all services rendered to minor patients, the authorizing adult accompanying the patient is responsible for payment.
- Human Dynamics & Diagnostics exercises the right to terminate the provision of services for non-payment of services rendered.
- All forms of insurance must be reported to the billing office. If you fail to provide copies of your insurance information or notify HDD of changes you will be charged a $50 reprocessing fee.
- It is your responsibility to know if a provider in our facility participates in your insurance plan. We are not responsible for determining whether or not our providers are in-network with your plan.
- Payment is due at the time of service. If insurance is billed, payment of outstanding balance is expected within 30 days of receiving your statement. An interest fee of 1.5% will be charged for all accounts over 90 days past due.
- If at least 90 days have passed from receipt of the final statement by the patient and final resolution of all internal reviews, good faith disputes, and appeals of any charges or third-party payor obligations or payments, and a payment has not been received, the account will be reported to collections. Human Dynamics & Diagnostics will use North American Collections, 1393 Cambridge Dr. Idaho Falls, Idaho 83401 208-522-8013 for all collection issues. *Title 48, Chapter 3, section 48-304 Requirements for Extraordinary Collection Action (5)* https://legislature.idaho.gov/statutesrules/idstat/Title48/T48CH3/.
- We accept cash, check, debit cards or credit cards. Payments can be made by mail, over the phone, or in the office. There is a $20.00 charge for all returned checks.
- We request that cancellations be made at least 24 hours in advance of scheduled appointments. We reserve the right to charge a late cancellation fee of $70 (as permitted by your insurance carrier).

I have read and understand the financial policy and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice. *A copy of this agreement is available to me upon request.*

Responsible Party Signature	Relationship to Patient	Date

HUMAN DYNAMICS & DIAGNOSTICS

CONSENT FOR TREATMENT

SERVICES: We adhere to the current local and national standards for behavioral health care and provide evidence-based treatments for mental health and developmental conditions. Services we provide include Medication Management, Counseling, Developmental Disability Services, and Family/Peer Supports. While we provide evidence-based treatments that are shown to improve symptoms, there is no guarantee that any service or medication provided will completely alleviate the symptoms addressed. Risks associated with these services include a worsening of your condition. Services are limited because of third party/Medicaid payer requirements and may be modified or ended due to payer policies. Third parties are billed based upon our fee schedule. You have the right to select your service provider, refuse these services and withdraw this consent at any time.

APPOINTMENTS: Office visits are by appointment only. When you call for an initial appointment, our Office Manager will ask a few questions regarding the nature and urgency of your concern or problems.

CANCELLATIONS: We request that cancellations be made at least 24 hours in advance of scheduled appointments. We reserve the right to charge a late cancellation/no-show fee of $70 (as permitted by your insurance carrier). It is your responsibility to keep the appointment you make.

TIMES: Appointments take approximately forty-five to fifty-five minutes.

EMERGENCY AND AFTER HOURS COVERAGE: If a life-threatening emergency arises after business hours, please proceed directly to the nearest emergency room or call 911. You may access the Suicide and Crisis Lifeline by texting or calling 988. An individualized safety plan will be developed at the initiation of treatment.

CONFIDENTIALITY: Your privacy is our priority and is protected by state and federal law. Limited confidential information can be released by the clinic without your consent in specific situations involving: 1) suspected neglect or abuse of a child, 2) life-threatening danger to you or other, as in cases of very high risk of suicide or threats of bodily harm against others, 3) if so ordered by a court or required by applicable law, and 4) if a medical emergency occurs while you are at the clinic and you require emergency treatment.

COORDINATION OF CARE: We will not release any records without your written consent, other than in the following circumstances: 1) Upon request from your referring physician we will send reports for coordination of care. You must tell us otherwise if you do not desire communication with your referring physician. 2) Your record may be reviewed by your insurance company. Your insurance claims will be submitted electronically or mailed with diagnostic code and a code for the type of treatment rendered. 3) It is at times necessary for providers within this agency, or contracted with this agency, to discuss your case in order to provide the best quality of care.

I understand the nature and purpose of this clinic and understand that no promises have been made to me as to the results of the treatment provided. I acknowledge that this consent has explained the proposed care in a satisfactory to me. *A copy of this agreement is available to me upon request.*

Responsible Party Signature	Relationship to Patient	Date

HUMAN DYNAMICS & DIAGNOSTICS

PATIENT'S RIGHTS, RESPONSIBILITIES, AND GRIEVANCE POLICY

As a client or guardian of a client receiving behavioral health services from Human Dynamics and Diagnostics, you have the following **rights**:

Professional Expertise: Clients or their guardian have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Clients or their guardian have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

HIPAA Privacy and Security: As detailed in Human Dynamics Notice of Privacy Practices and Confidentiality Statement, clients or their guardian(s) have the right to be guaranteed the protection of the confidentiality of their relationship with their behavioral health professional, except when laws or ethics dictate otherwise. Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care. Information technology will be used for transmission, storage, or data management only with methodologies that assure the protection of the client's privacy. Information shall not be transferred, sold, or otherwise utilized.

Choice and Consent: Clients or their guardian have the right to choose any duly licensed/certified professional for behavioral health services and consent to treatment. Clients or their guardian(s) have the right to receive full information regarding the education and training of professionals, treatment options (including risks, benefits and alternatives), and cost implications to make an informed choice regarding the selection of care deemed appropriate by client and professional. Clients or their guardian(s) also have the right to refuse treatment and withdraw consent for treatment.

Determination of Treatment: Recommendations regarding behavioral health treatment shall be made only by a duly licensed/certified professional in conjunction with the client and their family as appropriate. Treatment decisions should not be made by third party payers. Clients or their guardian(s) have the right to make final decisions regarding treatment.

Nondiscrimination: Quality behavioral health services shall be provided to all clients without regard to race, color, religion, national origin, gender, age, sexual orientation, or disability.

Contractual Limitations: Clients or their guardian(s) have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between the third-party payer and the treating professional that could interfere with or influence treatment recommendations. Clients or their guardian(s) have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

Treatment Review: To assure that treatment review processes are fair and valid, Clients or their guardian(s) have the right to be guaranteed that any review of their behavioral health treatment shall involve a professional having the training, credentials, and licensure required to provide the treatment in the jurisdiction in which it will be provided.

HUMAN DYNAMICS & DIAGNOSTICS

PATIENT'S RIGHTS, RESPONSIBILITIES, AND GRIEVANCE POLICY (continued)

Accountability: Treating professionals may be held accountable and liable to clients or their guardian(s) for any injury caused by gross incompetence or negligence on the part of the professional. Sexual intimacy is never appropriate between a treating professional and a client and should be reported to the treating professional's licensing board. The treating professional has the obligation to advocate for and document necessity of care and to advise the client of options if payment authorization is denied.

Complaints and Grievances: Clients or their guardian(s) have the right to submit complaints or grievance regarding provision of care by the treating professional to the owners of Human Dynamics and Diagnostics, as well as HDD's regulatory agencies. If a client has a complaint against the agency, they will be encouraged to make their complaint in writing to the owners of the agency. A written response will be generated and kept as part of the client's record for two years. For Medicaid participants: If the matter cannot be successfully reconciled, the client will be encouraged to contact Optum Idaho at (855) 202-0973.

As a client or guardian of a client receiving behavioral health services from Human Dynamics and Diagnostics, you also have the following **responsibilities**:

Participation and Engagement: You have the responsibility to participate actively and honestly in your or your loved one's treatment. You are responsible for asking questions about any policy, procedure, or treatment which you do not understand or with which you do not agree.

Respect: You are responsible for treating the personnel and clients of HDD with dignity and respect.

Informed Consent: You are responsible for carefully reading and understanding any papers you may be asked to sign in relation to your or your loved one's treatment.

I acknowledge and agree to the Patient's Rights, Responsibilities, and Grievance Policy. *A copy of this agreement is available to me upon request.*

Responsible Party Signature	Relationship to Patient	Date

HUMAN DYNAMICS & DIAGNOSTICS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access the information. Please review it carefully.

Our Responsibilities. We are required by law to maintain the privacy of your health information and to notify you of our legal duties and privacy practices with respect to your protected health information. This notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 C.F.R. part 164. We are required to abide by the terms of our notice that is currently in effect. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Your Rights Concerning Your Protected Health Information. You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- We normally contact you by telephone or mail at your home address. We will accommodate reasonable requests to contact you by alternative means or at alternate locations.
- You may request that we limit the information we share for treatment, payment, or our operations. We are not required to agree to your request if it would affect your care.
- You may request an accounting of certain disclosures we have made of your protected health information.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.
- You may designate an agent to exercise your rights and make choices about your health information. We will verify medical power of attorney or guardianship before taking any action.
- You may submit a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer identified below. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Your Choices Concerning Your Protected Health Information. You can choose how certain health information is shared.

- Unless you tell us otherwise in advance, we may disclose information to a member of your family, relative, friend, or other person who is involved in your healthcare or the payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment. If you object to such disclosures, please notify the Privacy Officer identified below.
- We will never share your information for marketing purposes without your written permission.

Uses and Disclosures We May Make Without Written Authorization. We may use or disclose your protected health information for certain purposes without your written authorization, including the following:

- ***Treatment***. We may use or disclose information for purposes of treating you, e.g., our staff may use your information or disclose your information to another health care provider to diagnose or treat you.
- ***Payment***. We may use or disclose information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

HUMAN DYNAMICS & DIAGNOSTICS

NOTICE OF PRIVACY PRACTICES (continued)

- ***Operations***. We may use or disclose information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to review the performance of our staff or make decisions affecting the practice.
- ***Other Uses or Disclosures.*** We may also use or disclose information for certain other purposes allowed by 45 C.F.R. part 164.512 or other applicable laws and regulations, including the following purposes:
  - Preventing or reducing a serious threat to your health or safety or the health or safety of others.
  - As required by state or federal law, e.g., to report suspected abuse, neglect, or certain domestic violence.
  - As allowed by workers compensation laws for use in workers compensation proceedings.
  - For certain public health activities, e.g., to report certain events or diseases.
  - For certain public health oversight activities, e.g., to allow public health agencies to conduct investigations or inspections.
  - In response to a court order, warrant or subpoena in judicial or administrative proceedings.
  - Subject to specific limitations, in response to certain requests by law enforcement, e.g., to help identify or locate a fugitive, witness or victim, or to report a crime.
  - For research purposes if certain conditions are satisfied.

Uses and Disclosures with Your Written Authorization. We will make other uses and disclosures of your information only with your written authorization. You may revoke your authorization by submitting a written notice to the Privacy Officer identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

Changes to This Notice. We reserve the right to change the terms of our Notice of Privacy Practices at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or the Privacy Officer identified below.

Complaints and Contact Information. Please contact our Privacy Officer if you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above.

Privacy Officer: Tasha Riedelbach
Phone: (208)522-1040 ext. 1216
Address: 2267 Teton Plaza, Idaho Falls, ID 83404
Email: tashar@humandynamicsid.com

I acknowledge that I have received a copy of the Human Dynamics & Diagnostics Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA). *A copy of this agreement is available to me upon request.*

Responsible Party Signature	Relationship to Patient	Date

HUMAN DYNAMICS & DIAGNOSTICS

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Patient Name_____ Date of Birth____/____/____ Phone_____

Address_____ City_____ State_____ Zip_____

Name of legally authorized representative_____ Relationship_____

SCOPE & PURPOSE FOR SHARING INFORMATION: I understand protected health information is information that identifies me. The purpose of this authorization is to allow Human Dynamics and Diagnostics to receive or share my protected health information as set forth below, for reasons in addition to those already permitted by law.

Persons/Organizations authorized to release or receive my information

Name, Address, Phone, Fax	Relationship	Purpose

Information to be shared (Check one or more boxes below.)

☐Entire Medical Record (includes all records except Psychotherapy Notes) ☐ Treatment Plans and Reviews

☐Comprehensive Diagnostic Assessment ☐ Progress Reports ☐History and Physical ☐ Laboratory Report(s)

☐Other:_____

Dates of Service ☐All dates of service ☐ Specific date or service_____

EXPIRATION AND REVOCATION:

This release will expire: ☐12 months from date of signature ☐Other date or event_____

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

ACKNOWLEDGEMENTS: I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

SIGNATURE: This document must be signed by the individual or the individual's legal representative.

Signature of Patient or Legal Representative	Printed Name	Date

HUMAN DYNAMICS & DIAGNOSTICS

PATIENT EMAIL AND TEXT COMMUNICATION CONSENT

As a patient of Human Dynamics & Diagnostics you may request that our organization communicate with you by electronic mail (email) and/or text message. This consent form will inform you about the risks of communicating with your health care provider, or any other organization, via email and/or text message and how Human Dynamics & Diagnostics will use and disclose provider/patient email and/or text message.

Email and text communications are effective protocols for two-way communications. However, responses and replies to emails and texts sent to or received by either you or any other party may be hours or even days apart. This means that there could be a significant delay in receiving treatment for one's condition. Therefore, if you have an urgent medical emergency situation, you should not rely solely on email and/or text with our organization for purposes of requesting assistance or to describe the urgent or emergency situation.

Text messages on your phone, computer, laptop, or other electronic medium or device have numerous privacy risks, particularly when your device is not password protected. If an email is not sent with secured technologies, such as encryption, the email (specifically, all of its contents) can be easily compromised in today's cyber world. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. You can also help minimize this risk by using only the email address or phone number that you provide to our practice/program/provider.

In order to forward or to process and respond to your email and text, personnel at Human Dynamics & Diagnostics (other than your health care provider) may read your email message. Your email and text message is not private communication between you and your treating provider. At your health care provider's discretion, your email and/or text message and any and all responses to them may become part of your medical record.

Communications over the Internet and/or using the email system and/or text message may not be encrypted and therefore, may not be secure. Because of this, there is no assurance of confidentiality, integrity, and availability (CIA) of the communication itself. Today's growing cyber security threats and challenges mean that at any given time, your communication – if not protected by encryption – can be compromised. If you are fully aware of this and still wish to have Human Dynamics & Diagnostics communicate with you via email and/or text message, please complete and sign this form below.

I certify that the email address and phone number provided to Human Dynamics & Diagnostics on this request is accurate, and that I accept full responsibility for messages sent to and from this address/phone number. I completely understand, am well aware and acknowledge that communication over the Internet and/or using any type of email or text protocol may not be encrypted, thus it may not be secure. I agree to hold Human Dynamics & Diagnostics and other organizations and individuals associated with such communication harmless from any and all claims and liabilities arising from or related to this request to communicate via email and/or text.

Patient Name_____ Phone (for receiving text messages)_____

Email address_____

How would you like to receive appointment reminders? Check one: ☐ Text ☐ Email ☐ No Reminder

_____ _____ _____

Signature of Patient or Legal Representative Printed Name Date

HUMAN DYNAMICS & DIAGNOSTICS

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. Telehealth services are used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. The platform used by providers will be HIPAA compliant such as doxy.me.
- I understand that I may opt out of telehealth services at any time. My Provider may also opt-out at any time.
- I understand that telehealth services can only be provided to patients, including myself, who are residing and located in the state of Idaho at the time of this service.
- I understand that it is my responsibility to check with my insurance plan to determine coverage of telehealth.
- I understand that all electronic medical communications carry some level of risk. These risks include:
  - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
  - Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
  - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree to verify to my provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose/treat a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing and request for an in-person visit.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I have read and understand the information provided above regarding telehealth and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in the course of my diagnosis and treatment at Human Dynamics and Diagnostics.

Signature of Patient or Legal Representative	Patient Name	Date

Medicaid clients only
if insurance is not Medicaid, please disregard

ICANS Informed Consent

I, _____ *(parent's name)*, am the parent or legal guardian of

_____ *(minor client's name)*.

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, WInS Wraparound Plan of Care, WInS Wraparound Crisis & Safety Plan, WInS Wraparound Transition Plan, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ (*name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency referenced in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 162 & 164; and Medicaid Regulations for safeguarding information, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any individual receiving alcohol or drug abuse treatment.

PURPOSE AND EFFECT.
I understand this authorization will allow my/my child or ward's treatment team to plan and coordinate services I need and will allow any person, entity, or agency referenced in this authorization to be actively involved in case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give permission for an open exchange of information to, by, among, or between, any person, entity, or agency referenced in this authorization. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time by submitting a Request to Restrict Access form to ICANSRestrictionRequests@dhw.idaho.gov. I acknowledge that revocation will prevent future disclosure of information in ICANS but will not impact any disclosures that have previously been made in reliance upon the executed Informed Consent Release form.

EXPIRATION.
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing, treating, or coordinating care for my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – *Required if Client is under 14 years of age.*	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**

ALERT® Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can. Then review your responses with your child's clinician. Please shade circles like this ●

Child's Name | Child's Date of Birth

Subscriber ID | Authorization #

Clinician Name | Today's Date (mm/dd/yy)

Clinician ID/Tax ID | Clinician Phone | State | *MRef*○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everthing	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the last week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following questions only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
24. In the past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days
25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? *(answer only if employed)* ☐☐ Days