NEW PATIENT REGISTRATION

Children Ages 1-12

Name:_____
First Middle Initial Last

Address:_____
City State Zip

Date of Birth:_____ **Gender**: ☐ Male ☐ Female **SSN**:_____ **Marital Status:** ☐S ☐M ☐D

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Employer: _____ **Employer Work Number:** _____

Emergency Contact: _____
Name Number Relation

Primary Care Physician: _____
Name Number

FINANCIALLY RESPONSIBLE PARTY (GURANTOR) INFORMATION (IF SAME AS ABOVE, PUT "SELF")

Guarantor Name: _____ **DOB:** _____ **SSN:** _____

Mailing Address:_____
City State Zip

Relationship to patient: ☐**Spouse/Significant Other** ☐**Mother** ☐**Father** ☐**Sibling** ☐ **Court ordered** ☐**Other** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Guarantor Employer and Phone Number: _____

As required by law, all minors under the age of 18 must be accompanied by a parent/legal guardian to see the therapist.

PLEASE TURN THIS FORM OVER AND FINISH FILLING OUT THE INFORMATION ON THE OTHER SIDE

PRIMARY INSURANCE INFORMATION

Name of Major Medical Insurance Company | Name of Insured (If Other Than Patient)

Member/Policy I.D. Number | Group Number

Address of Insured | Insured Employer

Insured Social Security Number | Insured Date of Birth

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

SECONDARY INSURANCE INFORMATION

Name of Major Medical Insurance Company | Name of Insured (If Other Than Patient)

Member/Policy I.D. Number | Group Number

Address of Insured | Insured's Employer

Insured Social Security Number | Insured Date of Birth

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Assignment of Benefits: I hereby authorize and request my insurance to pay directly to Oasis Behavioral Health Services the amount due for services rendered to me or my dependent.

Release of Information: I authorize the release of any medical information necessary to process this claim. This may include, but not be limited to, an outpatient treatment summary describing prognosis, frequency of treatment, and/or medications prescribed. This is a continuing consent for release of psychotherapy and/or substance abuse records for the duration of my treatment or until rescinded in writing.

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Oasis Behavioral Health Services. I understand Oasis Behavioral Health Services may take legal action to obtain payment if my account is in arrears and I have not made prior arrangements for payment. I will be responsible for any fees involved in the collection of this debt if sent to an outside collection agency or attorney. These fees will be added to my total amount due.

Signature (Patient signature, if patient is guarantor.) Date

Parent/Guardian Signature Witness Signature Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

_____ _____

Patient Name Date

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER *(check all that apply)*:

Home Telephone Number: _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Written Communication

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address
- ❑ O.K. to fax to this number: _____

Work Telephone Number: _____

- ❑ O.K. to leave message with detailed information
- ❑ Leave message with call-back number only

Other: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (FOR OFFICE USE ONLY)

DATE	DISCLOSED TO WHOM ADDRESS OR FAX #	(1)	DESCRIPTION OF DISCLOSURE/ PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T = Treatment Records, P = Payment Information; O = Healthcare Operation
(3) Enter how disclosure was made: F = Fax, P = Phone, E = Email, M = Mall, O = Other

Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement, if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information of only certain individuals involved in your care of the payment of your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician practice.
4. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the notice at any time.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Shawn R. Cade; PO Box 219; Barboursville, WV 25504. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures: We will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

_____	_____
Patient Signature	Parent/Guardian Signature
_____	_____
Witness Signature	Date

POLICIES

Thank you for choosing Oasis Behavioral Health Services. To ensure the privacy, respect, and courtesy to our patients, we enforce the following policies. Please do not hesitate to ask us if you have any questions.

Patient Name **(Print)**:_____ Birth Date:_____ Date:_____

Please initial each box to indicate that you have read and agree with these policies, and provide your full signature in the area indicated below by the (X). Thank you.

	See your doctor: If you have not had a physical examination in the past six months, please get a physical exam from your personal physician as soon as possible. Please ask your doctor to send us a copy of your physical exam results.
	Confidentiality: With a few exceptions, our conversations are confidential. State law, HIPAA regulations, and our codes of ethics specifically guarantee privacy. There are some situations, however, in which confidentiality cannot be guaranteed. They fall within the following categories: a. We must notify appropriate persons if we believe that a patient is an imminent danger to themself or others. b. We must report chid abuse or the abuse, neglect, or exploitation of the elderly. c. We will have to respond to a subpoena accompanied by a court order. d. If you are a participant in an insurance or managed care program, your contract may permit administrative access to your therapy record and require that we consult with your physician.
	Payments: Payment of co-pays, deductibles, or any balances not covered by insurance is **due at the time of service**. Returned checks are subject to a $25 fee. Postponement of services may occur under these conditions: No payment on account in the past 45 days, and/or your account is $150 or more in arrears. There will be a $3.00/month statement fee added to all unpaid balances.
	Appointment Cancellations: If you are unable to make your appointment for any reason, please cancel and reschedule as soon as possible. This allows us time to give your slot to someone on our waiting list. Failure to give 24 hours notice will result in a $50.00 missed or late-cancel charge to your account. This charge is not billable to your insurance company, and will be payable at your next scheduled visit. Missed-visits or cancellations for three consecutive appointments may warrant discharge from this episode of care.
	Incidental Fees: I acknowledge there may be charges my insurance might not cover that are necessary to facilitate care. These charges may include urine drug screens, testing, and/or educational materials. Oasis Behavioral Health Services will make every effort to inform you prior to providing the service, but we may not always know in advance. Your session fee may vary according to the service provided. I agree to be responsible for paying these charges.
	Charges for Telephone Consultations: Telephone consultations are *not* covered under insurance benefits. Any phone consultations are pro-rated by time and will be your responsibility to pay at the time of service or at your next scheduled appointment. You will also be responsible for charges related to case management consultations that your clinician determines is necessary to manage your care.
	Form Fees: There may be a charge for completion of reports or forms including, but not limited to: FMLA forms, disability forms, Workers' Compensation, record copying for legal purposes, etc. Fees will need to be paid in full before reports, copies, or forms are released. Check with your therapist for fee information.
	Emergencies: If you feel you need help and cannot reach your therapist, please contact your closest hospital E.R. or your local community mental health center. If your emergency is medication-related, then please contact the prescribing physician.
	Privacy Policy: I acknowledge being offered OBHS's "Notice of Privacy Policies and Client's Rights" form.
	Informed Consent: Before obtaining any medical or counseling care, it is important to gain sufficient knowledge regarding the types of treatment available, any risks, and potential benefits. This is done to ensure you can make well-reasoned decisions about your treatment. Your clinician will discuss with you the methods of therapy and any risks that may arise, and will be available to assist you in making any changes, and to help you understand their impact on you and others. We will always keep you informed of any changes in therapy we propose and any risks we foresee**.**
	Termination of Services: If you choose to stop treatment, we would appreciate a one week notice so that we might meet to discuss the cessation of services and your future plans. If you prefer, we can assist you in locating another provider. We also have the right to terminate services, and will provide you notice appropriate to termination conditions. Three consecutive failed-visits may result in temporary or permanent cessation of services.
	Electronic Communication and Social Networking: If you choose to communicate with anyone in this office by electronic means; i.e., cell phone, email, Facebook, Twitter, texting, etc., please be aware that confidentiality can ***not*** be guaranteed. Therefore, you are urged ***not*** to disclose any information via digital format that you would also not want made public. ***A special note about Facebook and Twitter:*** Individual clinicians in this office will ***not*** "friend" you on Facebook or "follow" you on Twitter, which could be interpreted as therapeutic boundary crossing. If you choose to "friend" us, please do so through our agency site at: http://www.Facebook.com/oasisbehavioralhealth.

X _____ _____/_____

Patient Signature | Parent/Guardian Signature | Date

_____

Witness Signature

OASIS BEHAVIORAL HEALTH SERVICES, L.L.C.

CONSENT TO TREAT A MINOR

I, _____, custodial parent/legal guardian of
(Parent/Guardian Name)

_____, age _____authorize:
(Name of Child)

OASIS BEHAVIORAL HEALTH SERVICES, LLC to assess and treat my child in an outpatient, psychological, counseling and psychiatric setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s). The treatment may also include recommendations for medications. If this occurs, you will be fully advised, so that you can make an informed decision about this mode of treatment.

Parent/Guardian Signature _____ Date _____

Relationship to Minor _____ Signature of Minor _____

Signature of Counselor _____Date _____

CHILD CUSTODY PAYMENT AGREEMENT

In the case of a divorce where there is a minor child receiving service from OASIS BEHAVIORAL HEALTH SERVICES, we must have one parent act as the legal guarantor for payment of services.

Any signature and contact information below acknowledges that I am responsible for the full payment of all fees for services provided by Oasis Behavioral Health Services (less any amount paid by a third party payer).

_____ _____
Print Name Address

_____ _____
Phone # City, State, Zip

_____ _____ _____
Social Security # Date of Birth E-mail

_____ _____
Emergency Contact Emergency Contact Phone Number

Signature:_____ Date: _____

************Please provide a copy of your Driver's License to the receptionist**************

O A S I S Behavioral Health Services, L.L.C.
710 Central Avenue
P. O. Box 219
Barboursville, WV 25504-0219
Office 304-733-3331 • Fax 304-733-3334
E-mail – wbwobhs1@aol.com
Website: www.PsychOasis.com

CHILD DEVELOPMENTAL AND PSYCHOSOCIAL HISTORY
(AGES 1 TO 12)

Please complete this form as fully as possible. The purpose is to obtain a complete and accurate profile of your child to assist us in helping him/her as quickly as possible. Please complete all questions to the best of your ability, and as honestly as you can. Any question which does not pertain to your child, just write N/A (not applicable) in the space provided.

If you are uncomfortable with answering any part(s) of this questionnaire, simply leave it blank and speak to your child's doctor or therapist about it.

The doctor or therapist will review this with you to assure accuracy and to elaborate where indicated.

This information is CONFIDENTIAL and will not be shared with anyone outside this office except in the following special circumstances:

- the legal guardian's written consent,
- a court order,
- if the child is in danger of hurting him/herself or others, (this may include alcohol and/or drug use),
- if the child is being abused.

Again, please complete each question, front and back pages. Thank you.

For Office Use Only:

Reviewed with client/patient's legal guardian: _____ Physician/Clinician Initials: _____
Date

1. General Information:

Child's Name: _____ Sex: F M Age: _____

Birth Date: _____ Social Security #: _____

Legal Guardian: _____ Social Security #: _____

Child Lives With: _____ Phone #: _____

Address: _____

Father's Name: _____ Age: _____

Father's Education: _____ Father's Job: _____

Father's Work Phone #: _____

Mother's Name: _____ Age: _____

Mother's Education: _____ Mother's Job: _____

Mother's Work Phone #: _____

Marital Status of Parents: Married ___ Single ___ Divorced ___ Widowed ___

If parents are separated/divorced, how old was the child when this occurred? _____

Stepfather's Name: _____ Age: _____

Stepfather's Education: _____ Stepfather's Job: _____

Stepfather's Name: _____ Age: _____

Stepmother's Education: _____ Stepmother's Job: _____

Siblings: Please list all biological, step, and half siblings (use back of form if necessary):

Name	Relationship	Age	Lives With the Child (if not, place of residence)

2. Method of Payment for Services:

Insurance Information: Insurance Company Name: _____

Address: _____

Policy and/or Group Number: _____

3. Presenting Problem: Please list your current concerns about your child and how long they have been occurring:

1. _____ 3. _____

2. _____ 4. _____

List any previous treatment, therapy or medication for these problems: _____

_____

Physician or therapist's name: _____

4. School Information:

Current School: _____ Grade Level: _____

Current Teacher: _____ School Counselor_____

How is your child's relationship with his/her current teacher? Good ___ Fair ___ Poor ___

Other adults at school your child trusts (nurse, counselor, principal, etc.): _____

_____

Has your child repeated any grades? If yes, which one(s)? _____

Has your child's performance in school changed as he/she has gotten older? If yes, how? _____

_____

Are you satisfied with your child's grades at this time? Yes ___ No ___

Has your child had psychological testing from the school? Yes ___ No ___ If yes, when? _____

Does your child have any special education assistance, such as learning disability, behavioral disorders, emotionally handicapped classes? _____

Does your child have any specific fears related to school? _____

_____

Please check below any school problems your child has:

	Never a Problem?	Always a Problem?	Recently a Problem?
Reading skills	_____	_____	_____
Math skills	_____	_____	_____
Social Studies	_____	_____	_____
Science	_____	_____	_____
Handwriting	_____	_____	_____
Not wanting to go to school	_____	_____	_____
Staying on task	_____	_____	_____
Completing classwork	_____	_____	_____
Working too slowly	_____	_____	_____
Working too quickly	_____	_____	_____
Conflict with teachers	_____	_____	_____
Not following rules	_____	_____	_____
Interrupting	_____	_____	_____

	Never a Problem?	Always a Problem?	Recently a Problem?
Fighting	_____	_____	_____
Getting out of seat	_____	_____	_____
Concentration problems	_____	_____	_____
Following oral directions	_____	_____	_____
Following written directions	_____	_____	_____
Organizing materials and tasks	_____	_____	_____

5. Developmental History: During pregnancy, did mother experience any of the following:

Excessive vomiting	_____	Toxemia (fluid retention)	_____
Hospitalization for complications	_____	Illnesses or operations	_____
Excessive spotting or blood loss	_____	Smoking during pregnancy	_____
Threatened miscarriage	_____	Drinking during pregnancy	_____
Infection(s)	_____	X-rays during pregnancy	_____

Medications taken during pregnancy _____ (If yes, please list) _____

_____

Was pregnancy full term? Yes ___ No ____ (If no, list length of pregnancy) _____

Were there any other pregnancy or delivery complications? If yes, please describe: _____

_____

Was jaundice, infection, Rh factor, or cyanosis (turning blue) present? (If yes, please circle any or all.)

Was your child placed in an incubator at any point? Yes ___ No ___

Birth defects? _____

Describe your child's personality during infancy: _____

_____

Did you child have any problems with sleep? _____

_____

Please check if your child had any problems with these developmental milestones:

Smiled	_____	Potty trained	_____
Crawled	_____	Rode tricycle	_____
Stood without support	_____	Rode bicycle	_____
Walked without assistance	_____	Dressed self	_____
Spoke first words (other than "mama, dada")	_____	Said alphabet	_____
Said phrases	_____	Began to read	_____

Does your child have any problems with motor coordination? (If yes, please list) _____

_____

6. Medical History:

Who is your child's primary doctor? _____ Phone #: _____

Address: _____

List current medications:

Medication	Dosage	Frequency	Prescribed By
(Example) Phenobarbital	15 mg.	2 times a day	Dr. Ross

Place a **checkmark** (✔) beside any illnesses/problems your child *has had in the past* and an **X** (✘) beside any illnesses/problems your child *currently* has:

___ Surgery
___ Measles
___ Mumps
___ Whooping Cough
___ Colic
___ Sexual Abuse
___ Physical Abuse
___ Verbal/Emotional Abuse
___ Emotional Outbursts
___ Problems Getting Along
___ Eye Problems
___ Ear Problems
___ Injuries
___ Learning Disabilities
___ Excessive Bed-wetting
___ School Problems
___ Mental Retardation/Slowness
___ Attention Deficit Disorder
___ Behavior Disorders
___ Prone to Violence
___ Self Harm
___ Suicidal Remarks/Attempts
___ Threatens Others
___ Allergies (If yes, to what?) _____

_____

6. Family History:

List any medical problems occurring in the child's immediate and extended family: _____

_____

Has any family member had head injuries, learning disabilities, or school problems? _____

_____

List any psychiatric problems in the immediate or extended family (substance abuse, anxiety, depression, mood swings, marital conflicts, etc.): _____

_____

8. Social and Psychological History:

List any stressors your child has experienced in the last three years: _____

_____

_____

What type of discipline is used in the home? _____

_____

Has this been effective with your child? _____

_____

What type of play activities and hobbies does your child enjoy? _____

_____

With whom does your child most often play? _____

_____

List your child's strengths: _____

_____

List your child's weaknesses: _____

_____

What would you like to be different as a result of your child's coming here? _____

_____

_____

May we contact your child's primary care physician? Yes____ No____

Primary Care Physician's (PCP) Name: _____

PCP Address: _____

_____

PCP Phone #: _____

Thank you for completing this questionnaire.

_____ _____

(Your Signature) (Date)