Omega Health Services
Child Intake (11 to 17 yrs old)

Welcome to our office. We would like to take this opportunity to say thank you for choosing us for your behavioral health needs. We look forward to providing you with personalized, comprehensive care.

Our office hours are generally Monday through Thursday 9:00 am to 5:00 pm and Friday 9:00 am to 3:00 pm. We also are open for our after-hours, walk-in clinic on Mondays and Thursdays from 5:00 pm to 8:00 pm. These hours may vary during the holidays. Any change in the schedule will be posted in advance on our door for each individual holiday.

Our office policy requires payment at the time of service. The following page lists our current fees so that you may plan accordingly. We do accept many insurances; however, ***we advise you to contact your insurance carrier to verify we are in-network with your specific plan prior to your visit and to verify your 'out-patient mental health' benefits, as they are often different than your general medical benefits. Your insurance company may also require authorization to be initiated by the patient and your visit may not be covered if you have not done this prior to your appointment.***

Again, thank you for choosing our office for your behavioral health needs. Please do not hesitate to contact us with any questions that you may have.

Omega Health Services

Below is a list of our basic fees. These fees may vary based on the time spent and the type of services required. If you have any questions regarding specific fees, please contact our billing department. If billing insurance, your fees will be based on the insurance companies negotiated rates and will never be more than our basic fees. Please note, we exhaust every effort to verify eligibility and network status prior to your appointments, and while our providers contract with many insurance plans and networks, we may not be contracted with yours. Omega will give you a 'good faith estimate' at each appointment based on the information we obtain while verifying your benefits.

Service	Fee
Initial Visit/Psychiatric Evaluation	$330.00 to $550.00
Established Pt Follow-up	$165.00 to $465.00
Initial Visit w/Therapist	$270.00
Individual Therapy w/ Therapist—16-37 mins	$150.00
Individual Therapy w/Therapist—38-52 mins	$185.00
Individual Therapy w/Therapist—53 + mins	$265.00
Family Therapy w/Therapist—with or without pt	$200.00 to $210.00
Injection (each)	$45.00
Urine Drug Screen	$25.00
EKG/ECG	$35.00
Blood Draw (Venipuncture)	$24.50
Court Appearance (**prepayment required)**	$300.00/hr
Report or Letter Preparation	$10.00 to $30.00
After Hours non-urgent calls	$10.00/call
Returned Checks	$25.00/incident
Missed Appts	100% of appt fee
Late Cancelled Appts	50% of appt fee

Please sign below to acknowledge reviewing our fees:

Signature:____Date:_______________

Patient Information

First Name | Middle Initial | Last Name | Nickname/AKA

Date of Birth | Social Security Number | Gender: ☐ Male ☐ Female | Preferred Pronouns

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Home Address: | Apt # | City | State | Zip

Home Phone #: | Cell Phone #: | Email:

Preferred Contact? ☐ Home ☐ Cell | Preferred Appt Reminder? ☐ Home ☐ Cell ☐ Email

Name of employer: | Employer Phone:

Responsible Party (Guarantor) Information

Relationship to Patient: ☐ Self (If Self, skip to Insurance Information) ☐ Spouse ☐ Patent ☐ Other

First Name | Middle Initial | Last Name

Date of Birth | Social Security Number

Home Address (if different): | Apt # | City | State | Zip

Home Phone #: | Cell Phone #: | Email:

Insurance Information

**Please note that if you do not have your insurance card, you may be responsible for your bill in full.*

***Primary Insurance Company name and address:**

Subscriber Name | Date of Birth: | SSN

Relationship to Patient | Policy #: | Group #:

***Secondary Insurance Company name and address:**

Subscriber Name | Date of Birth: | SSN

Relationship to Patient | Policy #: | Group #:

Emergency/Next of Kin Contact Information

Nearest Relative not residing with patient (First and Last Name)

Relationship to Patient | Home Phone #: | Cell Phone #:

Preferred Pharmacy and Location:______________________________

How Did You Hear About Our Office:

☐ Self-Referred ☐ Internet/Website ☐ Insurance Company

☐ Friend/Family ☐ Other Provider/Facility:______________________________

Name and Phone

*I hereby consent to treatment by providers at this office. I hereby authorize this office to release to my insurance company any information concerning illness and treatment necessary to expedite insurance payment. I understand that I am ultimately responsible for all charges, regardless of insurance coverage.

Patient/Parent/Guardian Signature: ______________________________ **DATE:** ____________

PLEASE UTILIZE
OUR PORTAL FOR:

MANAGING YOUR OWN APPOINTMENTS:

You can schedule, cancel, and verify your own appointment.

MANAGING YOUR MEDICATION AND CARE:

You can request refills, send messages to your provider to clarify directions or ask questions, and access visit summaries.

PLEASE FILL OUT THE FOLLOWING TO ACCESS THE PORTAL:

Do you wish to sign up for our online patient portal? Yes No
*If yes, you will need to give us your e-mail address to receive the invitation. (Circle One)

E-mail:____

Office and Financial Policy

Please carefully read and initial each statement.

1. Be aware that Omega strictly adheres to the State of Idaho's regulations concerning controlled substances and will not be able to fill these early for any circumstance. Also, be aware that we regularly check the Board of Pharmacy and will be notified if you seek controlled substances elsewhere. We require only 48-72 hour notice on controlled substance prescriptions. We will also require random Urine Drug Screens for any patients receiving controlled substances. **Any requests made prior to a maximum of 3 days early may be cause for termination of care by our office, regardless of the reason for the early request, without exception.** __________

2. I understand that the staff at Omega adheres to the rules and policies of the company and will try their best to help with any situation. I understand that any abusive or aggressive treatment or language directed at staff or providers may be grounds for termination. ___________

3. **I understand that if I 'no show' I will be charged 100% of my scheduled appointment time. I understand that if I 'late cancel' (cancel without 24 hr notice), I will be charged 50% of my scheduled appointment time. I understand that this fee is *NOT* covered by insurance. I also understand that if my account receives more than three missed appointments that my services may be terminated, and my care referred elsewhere, without exception.** __________

4. **I understand that arriving late for my appointment may be considered a 'late cancelation', and in some cases a 'no show', depending on when you show. Anything over half of the appointment time, your provider may not be able to see you, and there could be a charge for the missed appointment.** __________

5. I understand that if I request a personal copy of my records that **there is a charge for this service**. __________

6. **I understand that co-payments and patient portions are due at the time of service and are dictated by the insurance companies.** Failing to collect this payment is a violation of our agreement with your insurance company. Additionally, any patient balance that reaches 60 days will be assessed a 1.5% interest rate compounded monthly. Also, any patient balances that reach 60 days or over without contact or payment will be automatically transferred to collections and care will be terminated. __________

7. I understand that I am ultimately responsible for my bill, regardless of insurance status. I understand that it is my responsibility to contact my insurance company to verify benefits, provider contracting status, and authorization for treatment guidelines prior to my appointment. **Although our providers do contract with many insurance plans, they may not be contracted with yours.** __________

8. I understand that if I request forms to be filled out without an appointment, there is a fee for this service, and that fee depends on the length of time it takes my provider to complete the forms. I also understand that **I must follow up as directed and keep my account current or Omega will be unable to complete my forms.** __________

9. I understand that calling the afterhours answering service for **non-urgent issues such as routine prescription refills and scheduling questions** may result in a fee being assessed to my account. I also understand that **excessive calling may result in a charge on my account**, and the charge is at the discretion of my provider. __________

10. **I understand that if the patient is a child or adolescent, I am solely responsible for the account regardless of divorce or custody.** It will be my responsibility to seek reimbursement from any other parties involved. __________

I give my consent to the office of Omega Mental Health to fax labs/medication prescriptions to the pharmacy or lab of my choice. I have read, understood, and agree with all the above-listed consents and disclosures. Please know that **regardless of signature/initials on this page that all office policies will still be enforced**.

For:____

Print Patient Name DOB

____

Signature of Patient/Parent/Guardian

OMEGA MENTAL HEALTH

NOTIFICATION AND AUTHORIZATION OF CHARGE

Please carefully read, initial, and sign.

1. I am aware that, per office policy, any appointments that are cancelled late (without 24-hour notice) will incur a fee of 50% of the allotted scheduled time. I am aware that, per office policy, any appointment deemed a 'no show/no call' will incur a fee of 100% of the allotted scheduled time. I am also aware that if I incur a 'late cancellation' or 'no show' charge on my account that the credit card information listed below will be charged for this fee the day of the scheduled appointment. If there is a discrepancy with the charge made, and it is found to be an error, the amount charged will be refunded.________

2. I am aware that my account must be current at all times. If my account is not current and is scheduled for collections, and I have failed to return phone calls or respond to billing statements, I authorize the balance to be charged to the card listed below, in order to safeguard my credit._______

Visa MasterCard Amex Discover (circle one)

Account Number:______________________________
Expiration Date:_______________________________
Zip Code:____________________________________
Security Code:_______________________________________

Signature:____
Card member/account holder acknowledges terms and conditions and agrees to perform the obligations set forth by this agreement with the issuer.

OMEGA HEALTH SERVICES

Authorization for Communication of Protected Health Information to Family Members and Friends

Patient Name:____

Date of Birth:____

1. I authorize Omega Mental Health to discuss/share protected health information about me with the following individual(s) who are involved in my care:

THIS IS NOT FOR OTHER PROVIDERS INVOLVED IN YOUR CARE, THIS IS FOR FAMILY/FRIENDS ONLY

Name:	Relationship:	Phone No:
Name:	Relationship:	Phone No:
Name:	Relationship:	Phone No:

2. Type of information to be shared or disclosed:
   - ☐ Appointment Information
   - ☐ Prescription Information
   - ☐ ALL Information

3. I authorize Omega Mental Health to leave detailed phone messages about my medical and health plan information with the following:
   - ☐ Voicemail
   - ☐ Person Answering

This authorization shall remain in effect until revoked in writing by the patient.
Submitting a new form will revoke existing form.

X____

Signature of patient/authorized individual (minors aged 14 or older must sign this form themselves) Date

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________ **Age:** ________ **Sex:** ______________ **Date:** __________

Relationship with the child: ______________________________

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	○	○	○	○	○	
	2.	Said he/she was worried about his/her health or about getting sick?	○	○	○	○	○	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	○	○	○	○	○	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	○	○	○	○	○	
IV.	5.	Had less fun doing things than he/she used to?	○	○	○	○	○	
	6.	Seemed sad or depressed for several hours?	○	○	○	○	○	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	○	○	○	○	○	
	8.	Seemed angry or lost his/her temper?	○	○	○	○	○	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	○	○	○	○	○	
	10.	Slept less than usual for him/her, but still had lots of energy?	○	○	○	○	○	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	○	○	○	○	○	
	12.	Not been able to stop worrying?	○	○	○	○	○	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	○	○	○	○	○	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	○	○	○	○	○	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	○	○	○	○	○	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	○	○	○	○	○	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	○	○	○	○	○	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	○	○	○	○	○	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	○	○	○	○	○	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	○ Yes	○ No	○ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	○ Yes	○ No	○ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	○ Yes	○ No	○ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	○ Yes	○ No	○ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	○ Yes	○ No	○ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	○ Yes	○ No	○ Don't Know			

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DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: ______________________ **Age:** ________ **Sex:** ______________ **Date:** __________

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	O	O	O	O	O	
	2.	Worried about your health or about getting sick?	O	O	O	O	O	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	O	O	O	O	O	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	O	O	O	O	O	
IV.	5.	Had less fun doing things than you used to?	O	O	O	O	O	
	6.	Felt sad or depressed for several hours?	O	O	O	O	O	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	O	O	O	O	O	
	8.	Felt angry or lost your temper?	O	O	O	O	O	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	O	O	O	O	O	
	10.	Slept less than usual but still had a lot of energy?	O	O	O	O	O	
VIII.	11.	Felt nervous, anxious, or scared?	O	O	O	O	O	
	12.	Not been able to stop worrying?	O	O	O	O	O	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	O	O	O	O	O	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	O	O	O	O	O	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	O	O	O	O	O	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	O	O	O	O	O	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	O	O	O	O	O	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	O	O	O	O	O	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	O	O	O	O	O	
		In the past **TWO (2) WEEKS,** have you...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	O Yes			O No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	O Yes			O No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	O Yes			O No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	O Yes			O No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	O Yes			O No		
	25.	Have you EVER tried to kill yourself?	O Yes			O No		

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Today's Date ___________

Health History

Patient Name ________________________________ Age ________ Birth date ____________

Occupation ______________________________Last Physical Examination Date ____________

===

Are you allergic to any medications? If yes, please list them.

Have you or any member of your family been diagnosed with any of the following conditions? List affected family member, if applicable.

	Self	Family	Date
Abnormal Electrocardiogram	_____	_______________	_____
Cancer-where and what type	_____	_______________	_____
Cataracts/Glaucoma	_____	_______________	_____
Colon or Bowel Trouble	_____	_______________	_____
Diabetes	_____	_______________	_____
Epilepsy	_____	_______________	_____
Heart Murmur as Adult	_____	_______________	_____
Heart Attack	_____	_______________	_____
High Blood Pressure	_____	_______________	_____
Kidney Disease	_____	_______________	_____
Kidney Stones	_____	_______________	_____
Liver disease	_____	_______________	_____
Lung disease	_____	_______________	_____
Nervous system disorder	_____	_______________	_____
Poor Blood Clotting	_____	_______________	_____
Skin Condition	_____	_______________	_____
Stomach or Duodenal Ulcer	_____	_______________	_____
Sexually Transmitted Disease	_____	_______________	_____
Thyroid Disorder	_____	_______________	_____
MEN			
Prostate Problems	_____	_______________	_____
WOMEN			
Menstrual Difficulties	_____	_______________	_____
Cystitis	_____	_______________	_____
Ovarian Cyst	_____	_______________	_____
Other Gynecological Problems	_____	_______________	_____
Still Menstruating? Yes/No	_____	NA	_____

Age period started _____ Age period stopped _____ Number of pregnancies _____

Number of children _____ Number of miscarriages _____

Is there any chance you may be pregnant?

Hospitalization's and Dates:

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Parent please be thorough, but be ***brief*** with your responses when possible. Please respond to every item for complete accuracy.

Patients Name:____ DOB:________________Today's Date:__________________

Please ***briefly*** describe the reason for your child/adolescents visit or their current problem(s):

PAST PSYCHIATRIC HISTORY:

Has the patient previously been involved in mental health services? □Yes □No
Previous Counseling? □Yes □No If so, please ***briefly*** indicate ***with whom, from when to when and why?***

Please list what, if any, ***psychiatric medications they have taken in the past:*** None:____________

1) ______________________________________ 4) ______________________________________
2) ______________________________________ 5) ______________________________________
3) ______________________________________ 6) ______________________________________

Please list their ***current psychiatric medications*** (by name and amount taken each day): None:__________________

1) ______________________________________ 4) ______________________________________
2) ______________________________________ 5) ______________________________________
3) ______________________________________ 6) ______________________________________

Have they been ***hospitalized for psychiatric*** reasons? □Yes □No
How many times: ______________________

When (age, grade or date is fine) were they first ***psychiatrically hospitalized*** and ***why***?

When most recently and why?

Have they had any past suicide attempts? □Yes □No How many times: ___________________

If yes, ***by what method?***

If they have attempted suicide more than once, ***how old were they when first attempted, and when last?***

SAFETY ISSUES:

Does your child have access to any of the following?
________Large quantities of medications
________Firearms or other weapons: (list which types)____

Does your child have any other safety issue we should know about? ____
____

FAMILY HISTORY:

Do any members of your immediate or extended family have psychiatric illness? If so, can you name the diagnoses?

Have there been any completed suicides in your family? If so, who and when?

DEVELOPMENTAL HISTORY:
Were there any complications with pregnancy or delivery? □Yes □No
If so, briefly explain:

List any developmental problems your child has exhibited:

Any known ***Developmental Delays***? □Yes □No If not, proceed to **Medical History** below.

Motor skills: sitting at 6 months: □Yes □No Walking by one year? □Yes □No
If not, when?___________

Verbal skills: problems talking by 1 year: □Yes □No Speech therapy: □Yes □No

Social skills: Problems with interactions with others: □Yes □No
Same age friends: □Yes □No

MEDICAL HISTORY:
List any surgeries your child has had and when:

List any chronic medical illness your child has had (i.e. asthma, allergies, diabetes, etc...):

List any medications the child is currently taking for medical problems:

Are there any known allergies to medications? □Yes □No If yes, list below:

PSYCHOSOCIAL HISTORY:
Where was your child born? ___________________________
Who raised the child, biological parents? □Yes □No If not, briefly explain:

Child of original marriage or parents separated or divorced—if so, when?

With whom does the child currently live?

Childhood: OK?_______ Not OK?______________ If not, briefly state why?

Spirituality/Faith/Religious preference?____

History of having been physically/emotionally/mentally abused: □Yes □No
If yes, briefly explain over what age period & by whom:

History of having been sexually abused: □Yes □No
If yes, briefly explain over what age period & by whom:

KNOWN DRUG & ALCOHOL HISTORY:
Known drug or alcohol use? □Yes □No
If so, when did this begin? (What grade in school or how old):______________
What substances were used?

Has there been any substance abuse treatment? □Yes □No

TOBACCO HISTORY:
Never Smoked:__________

Current Smoker: ☐Yes ☐No

If yes, please answer the following:
How often?
________Some Days
________Every Day

How much?
________Less than one pack per day ________One pack per day
________Two packs per day ________More than two packs per day

Former Smoker: ☐Yes ☐No
How long ago did you quit:_______________________
How often did you smoke?
________Some Days
________Every Day

How much did you smoke?
________Less than one pack per day ________One pack per day
________Two packs per day ________More than two packs per day

LEGAL HISTORY/DETENTION:
Please describe any legal problems:

EDUCATIONAL HISTORY:
Current grade: __________________Ever held back? ☐Yes ☐No
Any Special Education:

Please describe any behavior problems at school:

For Office Use Only
Diagnosis:____

____

Initial Tx:____

____

Omega Health Services

Acknowledgment of receipt of Notice of Privacy Practices:

You may refuse to sign this acknowledgment

I have received a copy of this offices Notice of Privacy Practices.
Please ask receptionist for a brochure if needed

____
Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign.

Communication barriers prohibited obtaining the acknowledgment.

An emergency situation prevented us from obtaining acknowledgment.

Other:______________________________