Please keep this page for your information.

WELCOME TO SANCTUARY!

Our address is:
4737 Afton Place, Ste A
Chubbuck, Idaho 83202
*Phone: 208-417-0623
**Crisis phone : 208-339-3163
***Fax: 208-417-0641
Email: sanctuaryntc@gmail.com
Testing: a.hughes@sanctuaryntc.com
Office hours: 9AM-5PM M-F
(closed for major holiday's)

Please arrive 5-10 minutes before your scheduled time so that you can check in at the front desk. If you need to cancel, please give at least 2 hours notice if possible.

If you have a copay, please bring that with you to the appointment each time. Also, contact your insurance company to see if you have met your deductible, and what is owed today.

If anything changes such as: address, insurance, authorizations, primary care provider, medical history, medications, emergency contact, or current phone number...please notify us as soon as possible.

Member Contact Information

Date:_____

PATIENT INFORMATION

Name (First, MI, Last)_____Social Security #_____

Address_____City_____State_____Zip_____

Date of Birth _____ Age_____ Male_____ Female_____ How Long Have You Lived Here?_____

Home Phone_____ May We Call You At Home? Yes_____ No_____

Work Phone_____ May We Call You At Work? Yes_____ No_____

Cell Phone _____ May We Call You On Your Cell? Yes_____ No _____

Email: _____ May we contact you by email? Yes _____ No _____

What Number Should We Use For Your Reminder Call? _____ Drivers License Number _____

Occupation_____ Employer/School_____

How Long at this Occupation? _____ How Long At This Present Job? _____ Highest Grade Completed _____

Birthplace_____ Religion_____ Military Service _____

Who referred You to Our Practice? _____

Emergency Contact? Name_____ Phone _____Relationship:_____

IF PATIENT IS A MINOR/ OR HAS GUARDIAN:

Mother/Guardian Name_____ Address_____

Employer_____ Occupation_____ Social Security #_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth_____ Does Patient Live With This Parent/Guardian? Yes_____ No_____

Father/ Guardian Name_____ Address_____

Employer_____ Occupation_____ Social Security #_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth_____ Does Patient Live With This Parent/ Guardian? Yes_____ No_____

***If the patient is a minor, the parent or legal guardian whose name/signature appears in this paperwork is responsible for all charges after insurance.**

Last Updated ~ 8/22

Consent for Assessment and Treatment

This document/agreement contains important information about 1) our professional services, 2) our business practices.

Purpose and Mission of Sanctuary Counseling

Our mission is to foster the success of our members and their families through innovative, evidence based treatment for people of all walks of life, resulting in recovery and improved resiliency. Members will participate in assessment and treatment which builds on the individual's strengths and can expect to be treated with both dignity and respect.

Sanctuary Counseling will be recognized as a leader in clinical services, training, research, and advancing evidence based clinical treatment.

Neuropsychological & Psychological Services

Effective treatment depends upon the particular problems you are experiencing, as well as personality factors and establishing a good clinician-client alliance. Psychotherapy may call for more active disclosure and effort on your part. For therapy to be most successful, we recommend you work on the things we talk about during the session and at home. Psychological treatment includes potential for some risk as well as benefits. Since therapy involves discussing unpleasant aspects of your life, you may experience feelings, which may be temporarily uncomfortable. On the other hand, psychological treatment has been known to produce many benefits such as reduction in distress, solutions to specific problems, and better relationships. There can be no guarantees of what you will experience. Sanctuary Counseling attempts to minimize risks by employing well-trained clinicians and by frequent conversations with you about your progress.

The first few sessions will involve evaluation of your needs. By the end of this evaluation period, your clinician will be able to offer you an initial impression of your needs and a plan for what treatment might include, if you decide to continue with therapy. If you ever have any questions about procedures, you should discuss them whenever they arise.

Sanctuary Counseling hours vary during the week. Sanctuary provides full time voice mail, but you may not be able to reach your clinician who may be out of the office or seeing other clients. Your clinician will make every effort to return your call as soon as possible. If you are difficult to reach, please inform your clinician of times you might be available. Sanctuary Counseling does not currently provide emergency services (see Emergency Care and Crisis Situations).

Forensic (Legal) Services:

Sanctuary Counseling provides a variety of forensic services including evaluations and court testimony. If you know you may need these services, please let us know at the beginning or during services. We will be happy to provide what help we can. Importantly, presenting your clinician with an unexpected subpoena to testify or produce records for the courts rarely benefits you. Unfortunately, it is often interpreted by the legal system as deception or manipulation and typically damages the therapeutic relationship between you and your clinician.

Research & Training:

Sanctuary Counseling has secondary goals of training the next generation of mental health professionals and advancing psychological science. To this end, we are affiliated with Idaho State University. While the confidentiality of every member receiving services through the clinic is strictly maintained, your case may be discussed within the confines of the clinic for training and quality service improvement purposes. Further, if you are participating in services, you may be asked if you are willing to have a session recorded. However, prior to this occurring, you will be asked to specifically sign a form consenting to recording.

In addition, at times, research opportunities may arise for a family or individual in your situation. When these occur, you may be contacted to see if the opportunity is of interest to you. Of note, unless you specifically request otherwise, if you participate in

neuropsychological or psychological testing your anonymous data will be kept in our secure database for potential future research on individuals with your condition. To reiterate, in this situation your personal information will in no way be connected to your test data.

Emergency Care and Crisis Situations

Sanctuary Counseling is not able to provide emergency services, or psychiatric medications. Individuals who need emergency clinical access should contact 911 or access an emergency room or emergency provider such as the State of Idaho Department of Health and Welfare.

MEMBER'S RIGHTS AND RESPONSIBILITES

Member's Rights

Members have the right to:

- Receive information about services and member's rights and responsibilities.
- Be treated with respect and recognition of his/her dignity and right to privacy.
- Participate with practitioners in making decisions about his/her mental health care.
- A candid discussion of appropriate or medically necessary treatment options for his/her condition.
- Voice complaints or appeals about Sanctuary Counseling for the services provided by Sanctuary Counseling.
    - When concerns or complaints arise, a member can discuss it with any staff, volunteer, or student working for Sanctuary Counseling, with whom they feel comfortable. The concern will try to be resolved informally initially to the satisfaction of the member. If that is insufficient, the staff member can help the member participate in the formal grievance process.
- Make recommendations regarding Sanctuary Counseling members' rights and responsibilities policies.
- Care that is considerate and that respects his/her personal values and belief system.
- Personal privacy and confidentiality of information.
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Have family members participate in treatment planning. Members over 12-years-old have the right to participate in such planning
- Individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support.
    - Provision of services within the least restrictive environment possible.
    - An individualized treatment or program plan.
    - Periodic review of the treatment or program plan.
    - An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan.

- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:
    - Resolving conflict.
    - Participating in research, investigational studies, or clinical trials.
    - Designate a surrogate decision-maker if he/she is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.
    - Be informed, along with his/her family, of his/her Sanctuary counseling's rights in a language they understand.
    - Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations.
    - Be informed of rules and regulations concerning his/her own conduct
    - Be informed of the reason for any non-coverage determination, including the specific criteria or benefits provisions used in the determination.

- Inspect and copy their protected health information (PHI) and in addition:
    - Request to amend their PHI.
    - Request an accounting of non-routine disclosures of PHI.
    - Request limitations on the use or disclosure of PHI.
    - Request confidential communications of PHI to be sent to an alternate address or by alternate means.
    - Make a complaint regarding use or disclosure of PHI.
    - Receive a Privacy Notice regarding their PHI.

Member Responsibilities:

Members have the responsibility to:

- Supply information (to the extent possible), that Sanctuary Counseling's' practitioners need in order to provide care.
- Follow plans and instructions for care that they have agreed on with his/her network practitioner.
- Understand his/her health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Keep scheduled appointments and actively participate in treatment.

(Please initial) _____It is your responsibility to provide legal documents regarding child custody.

Assessment Referral List

Speech Language Pathology

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Occupational Therapy

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Physical Therapy

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Hearing

Portneuf Hospital- Physical Medicine Dept.

515 E. Benton Street

Pocatello, ID 83201

Ph 208-239-1490

Ph 208-239-1000

Current Developmental Disability Agencies in Southeast Idaho recognized by the

Idaho Department of Health and Welfare:

A New Hope

Adolescent and Child Development Center, LLC

Center Case Management and DD Services, LLC

Dawn Enterprises, Inc.

Grace Educational Opportunities, Inc.

Swift dba New Day Products and Resources, Inc.

Access Point Family Services, Inc.

Allies Family Solutions

Community Connections of Pocatello

Franklin County Development Services

Southeastern Idaho Developmental Center

Contact information for these agencies are available on request or by visiting the Idaho Department of Health and Welfare website. (Http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=sxQW30i645k%3d&tabid=398&mid=2068)

By signing below, I certify that I am aware of these agencies and choose to be a customer of Sanctuary Counseling of my own volition.

Informed Consent

Your signature below indicates that you have read this agreement and agree to its terms.

These matters have been explained to you and you fully and freely give consent to receive Sanctuary Counseling evaluation and/or treatment services.

_____
Name of Client(s) or minor child (please print)

_____ _____
Signature of Client(s) /for minor child Date

_____ _____
Signature of Representative of Minor Patient Date

_____ _____
Sanctuary: NTC Clinician/Witness Date

Last Updated ~ 11/27/22

Fees, Billing, and Payment Policy

Please Initial Each Item in the space provided*

_____ **Fees** for therapy sessions are listed as follows, but may be subject to change in special circumstances:

Intake (CDA, Intake Paperwork, Treatment Plan)	$240.00 p/evaluation
Case Consultation - Family/Individual	$180.00 p/session*
Family Therapy:	
Family with Client Present	$180.00 p/session*
Family without Client Present	$180.00 p/session*
Individual Therapy:	
30 Minute Session	$80.00 p/session*
45 Minute Session	$105.00 p/session*
60 Minute Session	$120.00 p/session*
Case Management	$15.00 p/unit**
Peer Support	$15.00 p/unit**
Family Support	$15.00 p/unit**
Group Therapy / Skills Training Class	$40.00 p/session*
Misc. letter writing	$25 per unit***
Neuropsychological/Psychological:	
Testing & Report Writing	$110.00 p/hour
Neuro-Testing Feedback	$180.00 p/session*
Forensic Services:	
Psychological/Neuropsychological Eval.	$150.00 p/hour
Expert Testimony	$150.00 p/hour
Therapy/skills training	$150.00 p/session*
Designated Examination/Testimony	$150.00 p/hour
Competency Evaluation	$150.00 p/hour
Misc. Report/Letters	$25 p/unit***

*Session (approximately 45 minutes – divisible/cumulative by 30-minute increments) *

**Unit (approximately 15 minutes) **

Any letter pertaining to your legal case, school, Health & Welfare, employment, service animal etc.

_____**Co-pay or Deductible**: You are responsible to make your co-pay, or deductible payment **prior to services** with Sanctuary Counseling for yourself, or family member under 18. If you are uncertain of the deductible or co-pay requirements, please contact the number on the back of your insurance card.

_____ **Family Therapy** must be covered by your insurance if you are requesting this service. Please contact your insurance company for restrictions to see if you qualify under your plan. You will be responsible financially for anything not covered under your insurance plan.

_____ **Legal:** Individuals requesting any services which require Sanctuary Counseling to hire a lawyer, are responsible for any and all legal fees acquired by Sanctuary's lawyers.

_____ **Private Insurance Coverage:** As a courtesy Sanctuary Counseling will bill your insurance claim for you. If your insurance company does not respond or pay within a reasonable time period (60 days), you will be responsible for the remaining balance. Sanctuary Counseling requires all copays to be paid on the day that services are rendered.

_____Sanctuary Counseling will work with your insurance company as long as your clinician is a contracted provider covered by your policy. It is very important that you understand what your insurance covers and does not cover. Sometimes prior authorization is required for mental health services, or the services are limited to a specific number of sessions, certain types of therapy, or assessment services or approved providers. Ultimately, you (not your insurance company) are responsible for full payment of Sanctuary Counseling fees.

_____ If you are more than **15 minutes late** for your appointment, you will be charged a $25.00 cancelation fee and may be asked to reschedule your appointment at that time.

_____ **Delinquent Accounts:** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your bill will be subject to a 5% Interest Rate per every 30 day billing cycle. Sanctuary Counseling has the option of using legal means to secure payment. This may involve contracting with a collection agency which requires us to disclose otherwise confidential information. In most collection situations, the only information Sanctuary Counseling releases are the client's name, contact information, such as address, the nature of the services provided, and the amount due.

_____ **Returned Checks:** All returned checks will be subject to an additional processing fee of $25.00.

_____ **Court Ordered Services:** Often court-ordered services are not covered by insurance companies. If necessary, please call your plan administrator to have your questions about covered services answered.

_____ **Missed or Late Appointments:** Should it be necessary to miss an appointment, please notify our office a minimum of 24 hours in advance. We understand that life can be unpredictable, but our clinicians strive to keep a punctual schedule and we expect our patients to follow the same guidelines. If you are more than 15 minutes late for an appointment, you may be asked to reschedule your appointment. If the issue of 2 or more un-kept appointments arise the clients regularly scheduled appointment will be discontinued and it will be the responsibility of the client to reschedule with the clinician another time in their schedule.

_____ **Patient Conduct:** Sanctuary Counseling promotes a positive working environment, and our clients, staff, and visitors have the right to feel save and protected in our care. We reserve the right to ask anyone that may jeopardize or compromise the health and well-being of our clients, staff, and visitors to leave our premises immediately. *Last Updated ~ 11/27/22*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE

This notice of Privacy practices describes how Sanctuary: Neuropsychology & Treatment Consultants handles confidential information, following state and federal requirements. All programs in Sanctuary: Neuropsychology & Treatment Consultants may share your confidential information with each other as needed to provide you with benefits of services, and for normal business purposes. Sanctuary: Neuropsychology & Treatment Consultants may also share your confidential information with others outside of Sanctuary: Neuropsychology & Treatment Consultants as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from Sanctuary: Neuropsychology & Treatment Consultants. We need these records to give you quality of care and services. We also need these records to follow various local and federal laws.

We are required to:

- Use and disclose confidential information as required by law.
- Maintain the privacy of your information
- Give you this notice of our legal duties and privacy practices for your information, and
- Follow the terms of the notice that is currently in effect.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law, HIPAA, provides privacy protections for medical records and new client rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. This notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that Sanctuary: Neuropsychology & Treatment Consultants has provided you with this information at the end of this session.

Confidentiality

Federal and state law protects the privacy of communication between a client and a psychologist/clinician. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations, Sanctuary: Neuropsychology & Treatment Consultants will only release information about your treatment to others if you sign a written authorization that meets certain legal requirements. In the following situations, no authorization is required:

a) Clinical information about your case may be shared fully within Sanctuary: Neuropsychology & Treatment Consultants by the staff for the purposes of supervision were applicable.
b) Personal information is also shared for Sanctuary: Neuropsychology & Treatment Consultants' administrative purposes such as scheduling, billing, and quality assurance. Sanctuary: Neuropsychology & Treatment Consultants' files are also available to insurance company auditors. Data contained in your file are available for archival research (i.e., reviews of records to describe Sanctuary: Neuropsychology & Treatment Consultants' referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. All staff members have been given training about protecting your privacy and have agreed not to disclose any information without authorization or approval of the Sanctuary: Neuropsychology & Treatment Consultants Clinic Director in mandated reporting situations (see Limits to Confidentiality).

c) On occasion Sanctuary: Neuropsychology & Treatment Consultants may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. If you do not object, it is our policy to tell you about such consultations only if it is important to you and your clinician working together. All consultations are noted in the client's records.
d) Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

Consultation

For your information, the clinical providers of Sanctuary: Neuropsychology & Treatment Consultants function as a team and routinely consult regarding each member's case in order to provide the most effective and comprehensive care possible. In addition, some providers may consult with supervisors or other professionals outside of this clinic. In these situations, all professionals involved are bound by the confidentiality policies outlined in this document and have been required to sign a confidentiality agreement if they have access to the personal health information of a member.

Emails Cell phones Computers, & Faxes

It is important to be aware that computers and un-encrypted emails, texts, and faxed communications can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy/confidentiality of the information contained therein. Emails, texts, and faxes are vulnerable in that server/communication companies have access to the information sent through them. Further, they can be accidentally sent to an incorrect address or computer.

To combat these risks, the computers of Sanctuary: Neuropsychology & Treatment Consultants are equipped with firewalls, virus protection, and passwords. Further all information is routinely "backed-up" on encrypted hard-drives. Sanctuary: Neuropsychology & Treatment Consultants will not utilize emails, texts, or faxes without your direction to do so. Please notify the staff of Sanctuary: Neuropsychology & Treatment Consultants if you would like to specifically avoid or limit the use of emails, texts, cell phone calls, phone messages, or faxes when conveying your personal health information. If you communicate confidential or private information via un-encrypted e-mail, text, fax, or phone message, Sanctuary: Neuropsychology & Treatment Consultants will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate with those modalities. Please do not use texts, emails, voicemail, or faxes for emergencies.

Limits to Confidentiality

There are situations where Sanctuary: Neuropsychology & Treatment Consultants may be required or permitted to disclose information without your authorization. These situations are unusual at Sanctuary: Neuropsychology & Treatment Consultants, but include:

a) If Sanctuary has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child, elderly person, or disabled person, it is required to file a report with the appropriate agency, usually the Department of Health and Human Services. Once such a report is filed, we may be required to provide additional information.
b) If a client communicates an explicit threat of serious physical harm and has the apparent intent and ability to carry out such a threat, Sanctuary: Neuropsychology & Treatment Consultants may be required to take protective actions. These actions may include contacting the police and/or seeking hospitalization for the client.
c) If we believe that there is an imminent or even, in our judgment, high risk that the client will physically harm himself or herself, we will also take protective actions.
d) Although courts have recognized clinician-client confidentiality, there may be circumstances in which a court would order Sanctuary: Neuropsychology & Treatment Consultants to disclose personal health or treatment information. We also may be required to provide information about court ordered evaluations or treatments. If you are involved in, or contemplating litigation, you could consult with an attorney to determine whether a court would be likely to order Sanctuary: Neuropsychology & Treatment Consultants to disclose information.

e) Sanctuary: Neuropsychology & Treatment Consultants is required to provide information to a legal guardian of a minor child, including a non-custodial parent.
f) If a government agency is requesting information for health oversight activities or to prevent terrorism (patriot Act), Sanctuary: Neuropsychology & Treatment Consultants may be required to provide it.
g) If a client files a worker's compensation case, Sanctuary: Neuropsychology & Treatment Consultants may be required, upon appropriate request, to provide all clinical information relevant or bearing upon the injury for which the claim was filed.
h) If a client files a complaint or lawsuit against Sanctuary: Neuropsychology & Treatment Consultants or professional staff, Sanctuary: Neuropsychology & Treatment Consultants may disclose relevant information regarding the client in order to defend itself.

If any of these situations were to arise, Sanctuary: Neuropsychology & Treatment Consultants would make every effort to fully discuss it with you before taking action, and would limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Professional Records and Clients Rights

The laws and standards of the mental health profession require that Sanctuary: Neuropsychology & Treatment Consultants keep Protected Health Information (PHI) about you in your clinical record. Generally, you may examine and/or receive a copy of your clinical record, if you request it in writing. There are a few exceptions to this access: 1) some of the unusual circumstances described above, 2) when the record makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to that other person or 3) where information has been supplied confidentially by others. Also, the clinic will not release copyrighted test information or raw data. Because these are professional records, they can be misinterpreted. For this reason, Sanctuary: Neuropsychology & Treatment Consultants recommends that you initially review them in the presence of your clinician, or have them forwarded to another mental health professional so you can discuss the contents. Sanctuary: Neuropsychology & Treatment Consultants keeps no additional notes (sometimes called psychotherapy or process notes) beyond that which is in the clinical record. In most circumstances, Sanctuary: Neuropsychology & Treatment Consultants is allowed to charge a copying fee for re-producing your records. If Sanctuary: Neuropsychology & Treatment Consultants refuses your request for access to your records, you have the right of a review of this decision (except for information supplied confidentially by others), which the Sanctuary: Neuropsychology & Treatment Consultants Clinic Director will discuss with you upon request.

Minors and Parents

Please be informed that according to state and federal law, any person with legal rights pertaining to a child (e.g., legal guardian or non-custodial parent) may have the legal right to terminate the child's services unless that person has given his/her signed, informed consent. As stated earlier, Sanctuary: Neuropsychology & Treatment Consultants will honor requests for information by a legal guardian of a minor child.

Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their clinical records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is Sanctuary: Neuropsychology & Treatment Consultants prerogative to request an agreement from parents that they consent to give up access to their child's records. If the parent's agree, Sanctuary: Neuropsychology & Treatment Consultants will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Parents may be provided a summary of their child's treatment when it is complete. Other communications will require the teenagers assent, unless Sanctuary: Neuropsychology & Treatment Consultants feels it is a crisis situation including personal risk or physical danger to the minor. If possible, such disclosures would be discussed beforehand with the teenager to minimize his/her objections and concerns.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. **Right to Review and Copy**
   You have the right to ask to review and copy your information as allowed by law.

   If you would like to ask to review and copy your information a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from our files, the fee will be 25 cents per page.

   You will be told if there is information we are legally prevented from disclosing to you.

2. **Right to Amend**
   You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

   If you would like to ask Sanctuary: NTC to change your information a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to the Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   We may deny your request if you ask us to change information that:
   - Was not created by Sanctuary: Neuropsychology & Treatment Consultants
   - Is not part of the information kept by or for Sanctuary: Neuropsychology & Treatment Consultants
   - Is not part of the information which you would be allowed to review and copy; or
   - We determine is correct and complete.

3. **Right to Restrict Health Information Disclosures**
   You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

   If you would like to ask Sanctuary: Neuropsychology & Treatment Consultants to not share your information, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction.

4. **Right to an Alternate Means of Delivery**
   You have the right to ask that we deliver your information to you at a different mailing address. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

   If you would like to ask for an alternate means of delivery of your information, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

   Reasonable requests will be approved.

5. **Right to a Report of Health Information Disclosures**
   You have the right to ask for a report of the disclosures of your health information. This report for disclosures will not include when we have shared your health information for treatment, payment for your treatment, or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request Regarding Records Form" is available at the Sanctuary: Neuropsychology & Treatment Consultants office. You must complete this form and return it to a Sanctuary: Neuropsychology & Treatment Consultants office staff member for processing.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs for providing the report. We will tell you the cost, and you may choose to remove or change your request at the time before any costs are charged to you.

Processing records requests/ HIPAA rules 30 days.

I acknowledge that I received my Sanctuary: Neuropsychology & Treatment Consultants' privacy practices form on _____/_____/_____, by my signature below.

_____
Name of Client(s) and/or minor child (please print)

_____ _____
Signature of Client(s) and/or minor child Date

_____ _____
Signature of Representative of Minor Patient Date

_____ _____
Sanctuary: NTC Clinician/Witness Date

Last Update ~ 9/22

Insurance Information Client:_____

Patients Primary Insurance Information: (We will need a copy of your Insurance Card and photo ID)

Insurance Company Name _____ ID #_____ Group #_____

Subscriber's Name_____ Date of Birth_____ SSN_____

Address (if Different From Patient) _____ City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Relationship to Insured (Circle One): Self/Spouse/Child/Other

Patient's Secondary Insurance Information: (We will need to copy your insurance card)

Insurance Company Name _____ ID #_____ Group #_____

Subscriber's Name_____ Date of Birth_____ SSN_____

Address (if Different From Patient) _____ City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Patient's Relationship to Insured (Circle One): Self/Spouse/Child/Other

All **co-payments will be collected** at the time of service. **If you do not have insurance, payment is expected the time of service.**

It is up to you to provide us with all information necessary to bill your insurance company. We do not guarantee payment. You will be responsible for payment of all services not covered by your insurance company. We will not bill your insurance company if you are seeing an out-of-network provider; you will be responsible for payment at the time of service. We can however, provide you with an invoice which contains all the necessary information for you to submit a claim to your insurance company for reimbursement. If you know your deductible has not been satisfied for the year, please pay at the time of service. We will bill your insurance company t give you credit for the allowable amount toward your deductible. **WE HAVE A 24 HOUR CANCELLATION POLICY. IF YOU MUST CANCEL YOUR APPOINTMENT, PLEASE GIVE US 24 HOURS NOTICE. IF YOU CANCEL YOUR APPOINTMENT LATE OR DO NOT SHOW UP, YOU WILL BE CHARGED IN FULL FOR THE APPOINTMENT. YOUR INSURANCE COMPANY CANNOT BE BILLED FOR THE CHARGE.**

ACKNOWLEDGEMENT: I have read the above policy statement and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account in a timely manner. I agree that in the event that costs and/or fees are incurred in connection with collection of my account. I will pay all such costs and fees, including but not limited to collection costs, attorney fees and all court costs.

AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER: I hereby authorize payment to my insurance company directly to my individual provider or employees of Sanctuary: NTC. I also give Sanctuary: NTC permission to appeal any denied claims on my behalf.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Sanctuary: NTC, and/or my individual provider to release to my insurance company any and all information they may require concerning my care.

I am the guarantor for the following individual (and for whom I give Sanctuary: NTC or my individual provider permission to treat). **If the patient is a minor; I am the guarantor and accept responsibility for all payments.**

_____ _____
Patient (Guarantor's Signature) Date

_____ _____
Guarantor's Signature for Minor Patient Date

_____ _____
Witness Date

Last Updated ~ 8/22

OPTUM®

Authorization for Release of Health Information

Individual's Full Name	Date of Birth	Member or Subscriber ID #

Individual's Street Address	City	State	Zip Code

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Optum in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose my Information:

I authorize Optum and its affiliates to disclose my individually identifiable health information to the following person(s) or organization(s):

Sanctuary
(Full Name of Person(s) or Organization(s))

4737 Afton Pl. Ste A, Clubbuck, ID 83202
(Full Address &/or Phone number of Person(s) or Organization(s))

Type of Information to be Disclosed:

☐ I authorize disclosure of all my health information, including information relating to claims, medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; **or**

☐ I authorize only the disclosure of the following information:

(Type of Information)

Purpose of Disclosure:

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose:

_____
(Explain Purpose)

****

_____ _____
Signature of Individual Date

_____ _____
Witness Signature Date

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member.

_____ _____
Signature of Individual's Representative Date

Personal Representative's:

_____ _____
Name Phone Number

_____ _____ ___ _____
Street Address City State Zip Code

(*For California and Georgia residents only*) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

PCL-PR

Patient Name:_____ Date:_____

Rater:_____(***please circle one***: significant other, spouse, friend, *parent*)

The most upsetting event experienced was _____ on _____.
(EVENT) (DATE)

	Below is a list of problems and complaints that youth sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much your child has been bothered by that problem **in the past month**.	Never	Rarely	Sometimes	Often	Very Often
1	Repeated disturbing *memories, thoughts,* or *images* of a stressful experience from the past?	0	1	2	3	4
2	Repeated, disturbing *dreams* of a stressful experience?	0	1	2	3	4
3	Suddenly *acting or feeling* as if a stressful experience *were happening again* (as if he/she was reliving it)?	0	1	2	3	4
4	Feeling *very upset* when *something reminded him/her* of a stressful experience?	0	1	2	3	4
5	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded him/her* of a stressful experience?	0	1	2	3	4
6	Avoiding *thinking about* or *talking about* a stressful experience or *avoiding having feelings* related to it?	0	1	2	3	4
7	Avoiding *activities or situations* because *they reminded him/her* of a stressful experience?	0	1	2	3	4
8	Trouble *remembering important parts* of a stressful experience?	0	1	2	3	4
9	*Loss of interest in activities* that he/she used to enjoy?	0	1	2	3	4
10	Feeling *distant or cut off* from other people?	0	1	2	3	4
11	Feeling *emotionally numb* or being unable to have loving feelings for those close to him/her?	0	1	2	3	4
12	Feeling as if *his/her future* will somehow be *cut short*?	0	1	2	3	4
13	Trouble *falling or staying asleep*?	0	1	2	3	4
14	Feeling *irritable* or having *angry outbursts*?	0	1	2	3	4
15	Having *difficulty concentrating*?	0	1	2	3	4
16	Being *"super alert"* or watchful or *on guard*?	0	1	2	3	4
17	Feeling *jumpy* or *easily startled*?	0	1	2	3	4

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, 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 named 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 & 164; and the Medicaid Act, 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 alcohol or drug abuse patient.

PURPOSES.
I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

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 or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of 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 16 years of age, but only after signed by client.*	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**

AUTHORIZATION TO RELASE OR EXCHANGE CONFIDENTIAL INFORMATION

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

4737 AFTON PLACE, STE A, CHUBBUCK, IDAHO 83202 PHONE: 208-417-0623 FAX: 208-417-0641

USE ONE SHEET PER PROVIDER/ CONTACT (ATTACH PHOTO ID)

TODAYS DATE:_____/_____/_____

PATIENT LEGAL NAME:_____ DOB:_____

PRIMARY CARE PROVIDER/ MEDICAL CLINIC: _____

PHYSICIAN NAME: _____PHONE:_____

ADDRESS: _____ FAX:_____

CLINIC/ DATE FAXED:_____/_____/_____ WITNESS INITIALS:_____

OTHER PROVIDER/ PERSONAL CONTACT: _____ PHONE:_____

NAME:_____ RELATIONSHIP:_____ FAX:_____

PLEASE INITIAL EACH CATEGORY OF SPECIFIC INFORMATION THAT YOU ARE ALLOWING TO BE RELEASED OR EXCHANGED. WRITE "NO" IN CATEGORIES OF THAT YOU ARE NOT ALLOWING TO BE RELEASED.

_____ 6 MONTH MEDICAL HISTORY & RECORDS _____ VERBAL COMMUNICATION AS NEEDED

_____PSYCHOLOGICAL EVALUATION _____ CDA/ TREATMENT PLAN(S)

OTHER:_____

(CHECK BOXES) THIS INFORMATION IS BEING RELEASED OR EXCHANGED FOR THE FOLLOWING PURPOSE(S):

☐ COORDINATION OF TREATMENT/ CARE ☐ FAMILY CONSULTATION ☐ OTHER_____

☐ I DECLINE GIVING SANCTUARY COUNSELING MY MEDICAL INFORMATION.

PRINTED NAME OF CLIENT/PATIENT_____ ☐ SELF ☐ PARENT/ GUARDIAN

SIGNATURE OF CLIENT/ GUARDIAN_____ RELATIONSHIP_____

CLINIC WITNESS:_____ TITLE:_____

***THIS RELEASE EXPIRES ONE YEAR FROM THIS DATE: ____/____/_____** **REVISED 03-01-2023**

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical, or other information is not sufficient for this purpose.

AUTHORIZATION TO RELASE OR EXCHANGE CONFIDENTIAL INFORMATION

SANCTUARY
COUNSELING & PSYCHOLOGICAL TESTING

4737 AFTON PLACE, STE A, CHUBBUCK, IDAHO 83202 PHONE: 208-417-0623 FAX: 208-417-0641

USE ONE SHEET PER PROVIDER/ CONTACT (ATTACH PHOTO ID)

TODAYS DATE:_____/_____/_____

PATIENT LEGAL NAME:_____ DOB:_____

PRIMARY CARE PROVIDER/ MEDICAL CLINIC: _____

PHYSICIAN NAME: _____PHONE:_____

ADDRESS: _____ FAX:_____

CLINIC/ DATE FAXED:_____/_____/_____ WITNESS INITIALS:_____

OTHER PROVIDER/ PERSONAL CONTACT: _____ PHONE:_____

NAME:_____ RELATIONSHIP:_____ FAX:_____

PLEASE INITIAL EACH CATEGORY OF SPECIFIC INFORMATION THAT YOU ARE ALLOWING TO BE RELEASED OR EXCHANGED. WRITE "NO" IN CATEGORIES OF THAT YOU ARE NOT ALLOWING TO BE RELEASED.

_____ 6 MONTH MEDICAL HISTORY & RECORDS _____ VERBAL COMMUNICATION AS NEEDED

_____PSYCHOLOGICAL EVALUATION _____ CDA/ TREATMENT PLAN(S)

OTHER:_____

(CHECK BOXES) THIS INFORMATION IS BEING RELEASED OR EXCHANGED FOR THE FOLLOWING PURPOSE(S):

☐ COORDINATION OF TREATMENT/ CARE ☐ FAMILY CONSULTATION ☐ OTHER_____

☐ I DECLINE GIVING SANCTUARY COUNSELING MY MEDICAL INFORMATION.

PRINTED NAME OF CLIENT/PATIENT_____ ☐ SELF ☐ PARENT/ GUARDIAN

SIGNATURE OF CLIENT/ GUARDIAN_____ RELATIONSHIP_____

CLINIC WITNESS:_____ TITLE:_____

***THIS RELEASE EXPIRES ONE YEAR FROM THIS DATE: ____/____/_____** **REVISED 03-01-2023**

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical, or other information is not sufficient for this purpose.

SANCTUARY

COUNSELING & PSYCHOLOGICAL TESTING

AUTHORIZATION FOR TEXT MESSAGING

Due to the changing world of technology and healthcare, Sanctuary can provide our clients with text messaging appointment reminders. Sanctuary believes strongly in protecting the privacy of our clients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Sanctuary via text messaging. Sanctuary does not share the names, addresses, and/or phone numbers of clients with any other company, or with any other client.

I authorize Sanctuary Counseling to send text message appointment reminders to me on my provided cell phone number. By signing I acknowledge and accept the risks of communicating through text messaging. If you have questions about risks, please talk to a Sanctuary representative.

Please write legibly.

_____ _____/_____/_____

Clients Name (print) Today's Date

_____ _____ _____

Authorized Individual Relationship Cell Phone Number

SANCTUARY COUNSELING AND PSYCHOLOGICAL TESTING

Psychological & Medical History

Part I: Demographic Information

Name: _____ Date of Birth: _____ Social Security Number: _____

Today's Date: _____ Age: _____ Gender: _____ Race/Ethnicity: _____

Social Support (where applicable) **Is the relationship good, bad, or other?**

Spouse/Significant Other Name: _____ _____

Former Spouse's/Significant Other's Names: _____ _____

Children's Names & Ages: _____ _____

_____ _____

Mother's Name: _____ _____

Father's Name: _____ _____

Step-Mother's Name: _____ _____

Step-Father's Name: _____ _____

Siblings Names & Ages: _____ _____

_____ _____

Treatment Providers **Coordinate care with this professional (authorization needed).** **Contact information?**

Medical Provider: _____ YES / NO _____

Psychiatric Medication Provider: _____ YES / NO _____

Psychotherapist/Counselor: _____ YES / NO _____

Other: _____ YES / NO _____

Part II: Reason for Referral

Please describe the primary reason for seeking assistance at this time:

_____

_____

Part III: Current & Past Treatment:

Have you participated in treatment for any of these problems?

Counseling/psychotherapy: When? _____ With whom? _____ Was it helpful? _____

_____ _____ _____

Hospitalization: When? _____ Where? _____ Was it helpful? _____

Other Treatment (Please describe):_____

_____

Previous Psychological/Neuropsychological Testing: _____

_____

_____

Medications:

Current:

Type & Dosage? _____ When?_____ Is it helpful?_____
Type & Dosage? _____ When?_____ Is it helpful?_____
Type & Dosage? _____ When?_____ Is it helpful?_____
Type & Dosage? _____ When?_____ Is it helpful?_____

Past:

Helpful Medications: _____
Ineffective Medications: _____

Part IV: Symptom Screening:

Please indicate the following **symptoms** or **problems** you have experienced now or in the past, **when they first occurred**, and also describe **how long** they were or have been present:

Symptom/Problem:	What age did it start?	Is it a (C) Current or (P) Past problem? How long did it last?	Did/does a family member have this problem? Who?
Mental Health Symptoms:			
Anxiety			
Depression			
Rapid Mood Changes			
High Levels of Stress			
Panic Attacks			
Chronic Worry			
Relationship Problems			
Suicidal Thoughts			
Trauma			
Drug Problems			
Alcohol Problems			
Chronic Anger			
Grief			
Visual Hallucinations			
Auditory Hallucinations (voices)			
Chronic Irritability			
Sexual Problems			
Sleep Problems			
Intrusive Thoughts			
Obsessive Thoughts			
Paranoia			
Thoughts of Harming Others			
Other:			
Other:			
Behavior Problems:			
Self-Injurious Behavior			
Suicide Attempts			
Impulsivity			
Hyperactivity			
Fighting			
Destruction of Property			
Deception			
Theft			
Pornography			
Verbal Aggression			
Socially Inappropriate			
Problems Making Friends			
Property Destruction:			
Threatening Behavior:			

Other:			
Other:			
Cognitive Problems:			
Attention Problems			
Short-term memory problems			
Long-term memory problems			
Poor Judgement			
Racing Thoughts			
Reading Problems			
Spelling/Writing Problems			
Learning Problems			
Migraines			
Concussions			
Loss of Consciousness			
Stroke			
Black-outs			
Seizures			
Head Injuries			
Other:			
Other:			
Developmental Problems:			
Prenatal Exposure to Alcohol:			
Prenatal Exposure to Drugs:			
Prenatal Exposure to Accutane:			
Parental Exposure to Chemicals:			
Prenatal Medical Problems:			
Birth Complications:			
Serious Newborn Illnesses:			
Late Walking:			
Late Talking:			
Speech & Language Problems:			
Problems Making Eye Contact:			
Overly Sensitive to Sound:			
Overly Sensitive to Textures:			
Poor Sensitivity to Sound:			
Poor Sensitivity to Pain:			
Late Reading:			
Late Toileting:			
Toileting Problems:			
Late Developing Humor:			
Unusual Sense of Humor:			
Overly Literal:			
Late Understanding Sarcasm:			
Late Social Development:			
Late Cognitive Abilities:			
Other:			
Other:			

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