



NEW DAY BEHAVIORAL HEALTH CENTER

Date Referral Received: _____ Appt. Scheduled With: _____ Date and Time of Appt: _____
Staff Initials: _____

OUTPATIENT CLIENT REGISTRATION FORM

CLIENTS LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ SEX _____

HOME PHONE _____ CELL PHONE _____ DATE OF BIRTH _____

CLIENTS SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

GUARANTOR INFORMATION (Name of person(s) responsible for payment)

SPOUSE'S NAME: _____ DOB _____ DOB _____ SSN _____

MOTHER'S NAME: _____ DOB _____ DOB _____ SSN _____

FATHER'S NAME: _____ DOB _____ DOB _____ SSN _____

PRIMARY INSURANCE: _____ PHONE: _____

SUBSCRIBER NAME: _____ DOB: _____ DOB: _____ SSN: _____

POLICY ID #: _____ GROUP # _____ EMPLOYER _____

SECONDARY INSURANCE: _____ PHONE: _____

SUBSCRIBER NAME: _____ DOB: _____ DOB: _____ SSN: _____

POLICY ID #: _____ GROUP # _____ EMPLOYER _____

OTHER INSURANCE: _____ PHONE: _____

SUBSCRIBER NAME: _____ DOB: _____ DOB: _____ SSN: _____

POLICY ID #: _____ GROUP # _____ EMPLOYER _____

IF MEDICAID/NC HEALTHCHOICE, LME-MCO(circle one): _____ Sandhills / Alliance
IF TRICARE, SPONSOR'S RANK _____ (Please see front desk if one of these is not your LME-MCO)

Please complete this section of the page only if client is a minor

WHAT IS THE CHILD'S LIVING ARRANGEMENT _____

WHO HAS LEGAL CUSTODY OF THE CHILD _____

SCHOOL GRADE _____ NAME OF SCHOOL _____

BROTHER'S AND SISTER'S NAMES _____

OTHER FAMILY MEMBERS IN NEW DAY BEHAVIORAL HEALTH SERVICES _____

If client is in DSS custody please fill in information below:

COUNTY IN WHICH CHILD IS IN CUSTODY _____ ADDRESS OF FACILITY _____

CONTACT PERSON FOR CLIENT _____ PHONE _____

FOR OFFICE USE ONLY

CLIENT NAME _____ MEDICAL RECORD # _____

THERAPIST PROVIDING SERVICES _____ CHILD OR FAMILY PHYSICIAN _____
ALLERGIES? _____
CLIENT EMPLOYER(Or father's if client is a minor) _____
OCCUPATION _____ WORK PHONE _____
SPOUSE'S EMPLOYER(Or mother's if client is a minor) _____
OCCUPATION _____ WORK PHONE _____
NUMBER OF DEPENDENTS _____ NUMBER OF FAMILY MEMBERS LIVING IN THE HOME _____
MONTHLY INCOME (FAMILY) _____ LIST NAMES OF OTHER PERSONS LIVING IN THE HOME _____

As a courtesy, we generally call to remind our clients of scheduled appointments. This may cause confidentiality concerns for you and because of this we would like to give you the opportunity to either request or decline this courtesy call. Please do so by initialing your preference: _____ PLEASE CALL _____ DO NOT CALL _____

WHO REFERRED YOU TO US? _____ MAY WE CONTACT TO EXPRESS OUR GRATITUDE? _____
IF YES, PHONE NUMBER AND ADDRESS _____

PLEASE DESCRIBE IN DETAIL THE PROBLEM THAT IS BRINGING YOU TO OUR FACILITY, INDICATE HOW LONG THE PROBLEM HAS BEEN GOING ON: _____

WHAT ARE YOUR NEEDS FROM THE FACILITY AT THE PRESENT TIME: _____

Providing information on race/ethnicity is voluntary and will be held confidential. This facility strives to provide services to all families in a culturally sensitive manner. In order to assist us in meeting the needs of our culturally diverse population, we ask that you complete the following section:

PLEASE SPECIFY THE CLIENTS CULTURAL/ETHNIC GROUP:

- White Black Hispanic
 Asian Other Bi-racial (biological mother): _____
(biological father): _____

NAME OF PERSON WE MAY CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____
ADDRESS (CITY, STATE, ZIP) _____

I AUTHORIZE THIS OFFICE TO RELEASE INFORMATION OBTAINED DURING EVALUATIONS OR TREATMENT OF THIS CLIENT TO THE INSURANCE COMPANY INDICATED WHICH IS NECESSARY TO EXPEDITE AND SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE PAYMENT OF BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THIS PROVIDER. MEDICARE REGULATIONS MAY APPLY.

CLIENT/LEGALLY RESPONSIBLE PERSON'S SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

CLIENT NAME _____ MEDICAL RECORD # _____

NEW DAY BEHAVIORAL HEALTH CENTER, PC

FEE AGREEMENT

Payment for services at New Day Behavioral Health Center is due when they are provided. As a courtesy to our clients and families, we will bill your insurance in accordance with information you provide to us. It is your responsibility to keep New Day Behavioral Health Center informed of any changes to your insurance coverage. You are obligated to pay any deductible or co-pay required under your insurance plan, at the time of service.

Charges are based on the type of service provided to you. If additional time or services (such as telephone sessions) are provided, a pro-rated fee will be charged. You remain legally responsible for all charges.

Below are a list of common services and fees that clients may encounter. Your provider will discuss these fees with you at the time of the request.

Letters/reports for your insurance company or another agency \$150.00 per hour

Court related costs-letters, testifying, forensic reports etc. \$175.00 per hour
(Costs for testifying include travel time from "door to door")

Services that are not covered by your insurance company \$150.00 per hour
(Certain types of testing, phone sessions, etc.)

You will be charged for all missed appointments. With sufficient notice, an appointment can generally be re-scheduled.

FAILURE TO GIVE 24-HOUR NOTICE OF CANCELLATION WILL RESULT IN A \$50.00 "NO-SHOW" CHARGE.

Note: Per CMS rules, Medicaid recipients will not be charged "no-show" fees but will be responsible for all other fees/charges. Medicaid recipients are responsible for informing New Day of changes in their insurance coverage or additional information needed to accurately bill Medicaid, -- e.g., start of/discontinuation of coverage, Medicaid as secondary insurance. If the recipient fails to provide New Day with such information, the recipient will be responsible for any monies owed for services rendered that are denied by Medicaid.

This financial relationship will continue as long as we provide services or until such time as you notify us that you wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. When an account becomes 60 days past due, professional collection may be utilized and/or legal action taken.

My signature below indicates that I have read and understand this fee policy. I agree to take responsibility for fees charged to my account.

CLIENT/LEGALLY RESPONSIBLE PERSON'S SIGNATURE _____

DATE _____

FOR OFFICE USE ONLY
CLIENT NAME _____ MEDICAL RECORD # _____



NEW DAY BEHAVIORAL HEALTH CENTER

AUTHORIZATION TO PROVIDE SERVICE

_____ (initial) It is my choice and I authorize New Day to provide service to my child/myself/my family (circle one). I understand that participation is voluntary and I may discontinue service at any time. I understand that my insurance provider may be billed for the services received. I understand that New Day is required to notify the referring agency of my participation, withdrawal, or dismissal from services.

In the event of an emergency situation, I grant permission to seek emergency care/services from a hospital or physician.

I have full understanding of the items initialed above and have been provided with a copy of this form. A copy will be retained in my child's/my case record. I have been given the opportunity to ask questions and seek explanations for any items that I do not fully understand. I voluntarily agree to participate in the program/service as documented in my Plan of Care.

Client Signature _____

_____ Date

Legally Responsible Peron's Signature _____

_____ Date

Witness Signature _____

_____ Date

01-2018

Client Name: _____

Record #: _____
Medicaid #: _____



NEW DAY BEHAVIORAL HEALTH CENTER

INFORMED CONSENT FOR TREATMENT

RIGHTS AND RESPONSIBILITIES

- As a consumer of service, I am aware that I have certain rights and responsibilities as a participant in the service.
 - I have the right to be treated with respect and dignity and to be free of abuse, neglect, exploitation and physical punishment.
 - I have the right of informed consent – to have services explained in a manner I can understand. To be informed what is to happen, expectations, benefits, hazards, and alternatives to the service. Informed consent offers me a way to participate in service planning and provision.
 - I have the right to have all information about myself and/or my family to be kept in confidence. Confidential information includes all forms, written, verbal, audio or videotapes, and electronic. Under law there are times when the right to confidentiality is no longer valid, these are:
 - Upon receipt of a court order to release information
 - In the event of a medical emergency
 - When there is suspicion of abuse and/or neglect
 - When there is a danger to self or others and/or threats of harm to self or others
- Note: If a Guardian Ad Litem has been assigned to advocate for the client, they will have access to your case record as part of their role and responsibilities. They will keep all records and information confidential as mandated in their job description.
- I have the right to choose a service provider agency or organization and to refuse service altogether. In the refusal of service, I take upon myself the consequences of such actions.
 - I have the right to make complaints about the service of New Day. I am responsible to communicate my complaint in writing to my primary service provider or his/her supervisor.
 - I am responsible to follow the rules of New Day Behavioral Health Center.
 - I am responsible to be an active participant in the Plan of Care/Service Plan.

_____(initial) I am aware and understand my rights and responsibilities as provided to me by New Day providers.

INFORMED CONSENT

_____(initial) I am aware of the services planned for myself/my child. I will participate in the development of a Service Plan and agree to its content. I am aware of the benefits and potential risks of the program/service. I have been provided the opportunity to discuss the Plan of Service and possible alternatives. I agree to participate in the program and understand my participation is voluntary. I agree to participate in programs/service.

01-2018

Client Name: _____

Record #: _____
Medicaid #: _____



NEW DAY BEHAVIORAL HEALTH CENTER

NOTICE OF GRIEVANCE PROCESS

It is the policy of New Day Behavioral Health Center (New Day) to provide a mechanism for clients/families/legally responsible persons (LRP) to communicate complaints or grievances with the intent of resolution and improved satisfaction with service delivery systems.

In the event that you have concerns about the service provided to you at New Day and would like to file a complaint, please follow the process listed below:

1. Clients/families/LRPs are encouraged to express displeasure, problems, complaints and/or grievances to their primary service provider first.
2. If the difficulty is with the service provider, communication of problems should be addressed to New Day's Owner.
3. It is recommended that problems be presented in writing. This written document should contain specifics of problem: for example, what happened, when, who was involved. State the nature of the problem clearly and expectations for resolution.
4. Upon receipt of the problem communication the primary service provider or owner will contact the client/family member/LRP within three working days. If phone contact is not possible, written communication should be sent to client/family member/LRP within three working days. Discussion should focus on specifics of problem and possible methods of resolution.
5. Efforts should seek to resolve the problem with the client/family member/LRP within 10 working days. New Day's owner will make every effort to assist the client/family member/LRP in gaining resolution of problem to the best of their ability.
6. If resolution is not possible by the owner, the owner will assist the client/family member/LRP in linking to services elsewhere.
7. If resolution is not possible or is unsatisfactory, the problem may be forwarded by the consumer to an impartial agency or consumer advocacy group(s), such as the Office of Disability Rights or the appropriate Managed Care Organization (MCO). Phone numbers for the Office of Disability Rights and the MCO will be provided to clients at the beginning of service.
8. Appeals related to service reduction, denial, or discharge from service shall be communicated to the specific provider or the New Day owner. Appeals processing will follow Medicaid guidelines, where applicable.

NC Division of MH/DD/SAS

Office of Advocacy and Customer Service
1-919-715-3197 OR 1-800-662-7030

Disability Rights, NC

1-919-856-2195 OR 1-877-235-4210

NC LCSW Board 1-800-550-7009

NC LCAS Board 1-919-832-5975

NC LMFT Board 1-919-654-6914

Alliance Behavioral Health

1-877-235-4210

DHHS-919-855-4800

NC LPC Board

1-844-622-3572

NC Psychology Board

1-828-262-2258

NC Medical Board

1-800-253-9653 OR 1-919-326-1100 OR 1-919-326-1109

How to file a complaint related to my services, if necessary, has been explained to me and I have been given a copy of this process.

Client name _____

Witness _____

Date _____

Client/Legally Responsible Person's Signature _____

Date _____



NEW DAY BEHAVIORAL HEALTH CENTER

NOTICE OF CLIENT RIGHTS

New Day Behavioral Health is committed to supporting and protecting the basic rights of each client and their family members that are provided services. These Rights include but are not limited to:

- A. The right to the least restrictive, most appropriate, and effective positive treatment available.
- B. The right to reasonable enjoyment of privacy, in a clean and safe surrounding.
- C. The right to enjoy freedom of thought, conscience and religion, and the right to receive service in a manner that is non-coercive and that protects the right of self-determination.
- D. The right to have his/her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his/her life, the right to participate in the development of the plan of services to be offered by New Day and to be informed of expectations of all parties involved in the implementation of the plan.
- E. The right to receive appropriate and reasonable guidance, support, and supervision, and to be taught to fulfill appropriate responsibilities.
- F. The right to treatment regardless of age or degree of illness or disability.
- G. The right to be protected from all forms of sexual exploitation, sexual advances, sexual harassment, or sexual offenses of any nature.
- H. The right to access his/her case files for the purpose of review, correction or addition as specified in the policy on client records.
- I. The right to receive care in a manner that recognizes variations in cultural values and traditions.
- J. The right to be free from coercion with regard to religious decisions.
- K. The right to not be identified in connection with publicity for the agency which shall bring the client or the client's family embarrassment, and the right to have his/her identity protected in the context of any agency reports, statistical analyses or case summaries published.
- L. The right to not participate in public performances against the wishes of the person served or without the informed consent of that person and, in the case of a minor, of both the person served and the legally responsible person.
- M. The right to not be forced to acknowledge in public, dependency on or gratitude to New Day.
- N. The right to fully understand his/her treatment plans, to have the treatment plan thoroughly explained to him/her, the right to have the treatment plan written in a language that the client can understand and the right to receive a copy of the treatment plan. If a copy of the plan is desired, communication with the treating provider is recommended. The treating provider along with New Day records staff will assist the client in obtaining a copy of the treatment plan. When communication barriers exist, New Day will contract with professionals as needed to facilitate communication.
- O. The right to access an attorney or guardian ad litem and meet with them privately and the right to contact and consult with other legal or medical providers at his/her own cost.
- P. The right to confidentiality of all client records with release or obtainment of any confidential information, except as permitted by law and interpreted by agency counsel, to be limited by written prior consent from the client and/or legally responsible person (LRP).
- Q. The right to information that allows an informed choice about the use of services, including the range of services available at New Day, and the benefits and risks of proposed services.
- R. The right to refuse any service, medication or treatment without threat of termination, unless such rights have been limited by law or by court order, and to be informed of the potential consequences of such refusal (i.e. continuation of symptoms, deterioration, or a change in the agency's ability to provide services.)
- S. The right to be informed in writing prior to service delivery or at the time of service of any fees for service, the agency's expectations with regard to outcomes, the client's responsibilities, hours during which services are available, any rules established to govern client conduct, and reference to any activities which could result in discontinuation of services.

- T. The right to request and receive a complete copy of New Day's Client Rights Policy (acknowledgement of receipt will be kept in the client record.) (Special accommodations shall be made as necessary to ensure that non English speaking clients, the visually impaired, and the hearing impaired are fully informed of their rights and responsibilities.)
- U. The right to file a complaint according to the New Day Grievance Policy and Procedure if the client or the client's LRP feels any of their rights have been violated, or to express dissatisfaction with services provided.
- V. The right to access all civil rights.
- W. The right to contact the Disability Rights, NC for Persons with Disabilities.

Special Protections:

- A. New Day prohibits requiring a client's direct involvement in funds solicitation for the facility.
- B. New Day prohibits a client's participation in any activity involving audio or visual recording and research without the voluntary signed, time limited consent of the client and/or the client's LRP.
- C. Any client of New Day will not participate in or be subject of any research project without their informed, written consent.
- D. New Day's staff members and contracted providers are required to immediately report any alleged violations of a client's rights to the Owner. Any staff member or contracted provider who reports such an incident in good faith shall not have their status jeopardized in any way.
- E. Employees/contracted providers will protect clients from harm, abuse, neglect, and exploitation.
- F. Employees/contracted providers will not subject a client to any sort of abuse or neglect.
- G. Staff/contracted providers will not sell to or purchase personal property from or to clients.
- H. New Day does not use restrictive interventions.
- I. Any violation of paragraphs F through H of this article is grounds for employee dismissal or contract termination for Unsatisfactory Performance.

I have received a copy of the Client Rights as required by the North Carolina Confidentiality Rules for Mental Health, Developmental Disabilities and Substance Abuse Services (APSM: 45-1).

Client Name

Witness

Date

Client/Legally Responsible Person's Signature

Date



NEW DAY BEHAVIORAL HEALTH CENTER

NOTICE TO CLIENT REGARDING COORDINATION OF CARE

New Day Behavioral Health acknowledges the importance of maintaining relationships between outpatient behavioral health service providers, primary care providers and/or other professionals involved in our client's care. These relationships allow for clients and their providers/professionals to work collaboratively in making healthcare decisions. In an effort to facilitate this process, New Day Behavioral Health will adhere to the following procedures:

- A. New Day will ensure that each client, where appropriate, has a referral for outpatient treatment from the PCM and/or professional responsible for client's care.
- B. New Day will inform clients of this policy at the time of request/registration for services by including a statement to this effect in the client registration packet, and will obtain client's/legally responsible person's signature at the time of admission for services.
- C. New Day will obtain a signed release of information form from the client or legally responsible person prior to releasing information to the referring provider, PCM, or other involved professional(s).
- D. New Day will provide initial feedback to the referring provider and/or other involved professional(s) following the client's initial assessment and evaluation in the form of a summary letter and/or copy of the client's treatment plan.
- E. New Day will provide updates to referring providers/PCM's and/or other involved professionals regarding client's progress, as deemed necessary, to facilitate client's successful progress in treatment.

I have reviewed and/or received a copy of the New Day Behavioral Health Coordination of Care Policy and Procedure. I also understand that it is my responsibility to inform New Day of any changes in my/my child's PCM or any other professional involved in my/my child's care.

Client Name/MRN

Witness

Date

Client/ Legally Responsible Persons Signature

Date



NEW DAY BEHAVIORAL HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

This Notice describes how we may use and disclose medical information about you and how you may gain access to this information.

WE ARE REQUIRED BY LAW TO PROTECT YOUR HEALTH INFORMATION

Much of the information we collect about you is referred to as “protected health information” (PHI). This information has the potential to identify you as an individual. We maintain this information about you in your medical record. Some PHI may also be maintained in electronic records. We are required to follow the guidelines established in this Notice of Privacy Practices. We reserve the right to change the terms of this Notice at any time. You have the right to request a copy of changes made to this Notice. Any changes made to this Notice will be available for your review in our office.

WE MAY USE AND DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION

New Day Behavioral Health Center may use and disclose your PHI without your consent for the following reasons:

- **For Treatment**-We may use or disclose information with health care providers who are involved in your health care. We may also disclose PHI to another physician if that physician referred you to us for services. This may also include clinical notes as requested by your insurance company or referring provider.
- **For Payment**- We may share your PHI with agencies for the purpose of billing and for services provided to you. This information may include data that identifies you, such as your SSN, DOB and name.
- **For Health Care Operations**-We may use or disclose information to manage our programs and activities such as assessing the quality of services that you receive.
- **Appointments and Other Health Information**-We may send you reminders for care or appointments scheduled. We may also send you information about other services that may be of interest to you.
- **For Public Health Activities**-We may use or disclose PHI as required by law to report certain communicable diseases to health agencies. For example, we are required to report any cases of HIV, certain STDs and tuberculosis to the Health Department.
- **As Required by Law and for Law Enforcement**-We may disclose your PHI: in response to a court order; to avoid harm or avert a serious threat to a person or the public; when reporting abuse, neglect or exploitations.
- **For Health Oversight**-We may use or disclose your PHI when necessary to inspect or investigate health care providers.
- **For Government Programs**-We may use and disclose information for public benefits under other government programs, such as the determination of Supplemental Security Income (SSI) benefits.
- **Disclosures to Family, Friends and Others**-We may disclose information to your family or to other persons who are involved in your care. You have the right to object to the sharing of information with any persons within this classification. We will make every attempt to honor any reasonable wishes in regard to restricting the PHI information shared; however, we retain the right to deny your request if it interferes with our ability to conduct treatment, payment or other health care operations.
- **In Emergency Situations**-We may use or disclose information as necessary to meet the demands of emergency situations, such as medical, psychiatric, or behavioral conditions that require immediate attention.



NEW DAY BEHAVIORAL HEALTH CENTER

It is important for you to remember that we will use and disclose only the minimum amount of PHI necessary to comply with the above requirements.

Any other use or disclosure of your PHI requires your written authorization

- **You have the right to review and receive copies of your records-**If it is determined by a clinical professional that the information you requested could prove detrimental or harmful to you or someone else, we will deny access to only that specific information. We may choose to have specific information summarized and present you with that summary information. We cannot provide copies of any information sent to us by another source.
- **You have the right to request, to correct or update your records-**You have the right to request an amendment to your PHI in writing along with an expiration date for such an amendment.
- **You have a right to request a list of disclosures-** You have a right to request a list of disclosures of your PHI. You must make this request in writing.
- **You have a right to request limits on uses or disclosures of PHI-** You have a right to request that we restrict how your information is used or disclosed. We are not required to honor this request. Such a request must be made in writing.
- **You have a right to revoke your authorization for us to share or disclose information about you-**You must make this request in writing
- **You have a right to choose how we communicate with you-**You have a right to request how we contact or communicate with you. This request must be made in writing.
- **You have a right to file a complaint-**You have a right to file a complaint if you do not agree with how New Day Behavioral Health Center has used or disclosed your information.
- **You have a right to request a copy of this Notice-**You have a right to request a paper copy of this Notice at any time. Such a request must be made in writing.

How to File a Complaint or Report a Problem

If you believe we have violated your privacy rights or want to report a problem or complaint about how we have used or disclosed your information about you, you may do so by contacting the following:

Dr. Sonia M. Rhodie
New Day Behavioral Health Center, PC
1830 Owen Drive. Ste 203
Fayetteville, NC 28304
910-483-6427 x103

Client Name _____

Witness (Office staff) _____

Date _____

Legally Responsible Persons Signature _____

Date _____



NEW DAY BEHAVIORAL HEALTH CENTER

NOTICE TO CLIENT REGARDING AFTER HOURS ACCESS TO CARE

New Day Behavioral Health acknowledges the importance of continuity of care and access to providers during times of crisis and/or emergency. In an effort to provide our clients with access to providers outside of our normal hours of operation, clients are encouraged to adhere to the following procedure:

- A. Contact New Day at (910)483-6427.
- B. Once you have reached the answering service, please provide the following information:
 - a. Caller's Name
 - b. Client's Name and Address
 - c. Date of Birth
 - d. Name of Provider
 - e. Last appointment with provider.
 - f. Reason for your call.
 - g. Number where you may be reached for a return call.
- C. Once your information has been received, the answering service will contact the on call provider and share the information you have provided. The on call provider will then contact you to discuss your concerns.

I have reviewed and/or received a copy of the New Day Behavioral Health Center After Hours Access To Care Policy and Procedure.

Client Name _____

Client/LRP Signature _____

Witness _____

Date _____

Date _____



NEW DAY BEHAVIORAL HEALTH CENTER

NOTICE TO CLIENT REGARDING MISSED APPOINTMENTS

New Day Behavioral Health acknowledges the importance of consistent participation in therapy to obtain maximum benefits. Therefore, it is important that clients maintain consistent appointments and participation in therapy as outlined in their treatment plans and/or discussed with their provider. A consistent pattern of missed appointments is considered noncompliance with treatment recommendations and may result in reduced overall improvement and/or alleviation of symptoms. In an effort to maximize our client's benefit from services, New Day will adhere to the following policy regarding missed appointments:

- A. If a client does not keep their initial/first appointment, the provider has the option of not allowing the client to reschedule the appointment.
- B. Clients who "no show" for their follow-up appointments may receive a letter from their provider, or a telephone call from the office regarding the missed appointment. Clients will be encouraged to contact the office to reschedule the missed appointment to maintain consistency in care.
- C. Clients who demonstrate a pattern of missed appointments in the form of 3 or more late cancellations (same day cancellation) or "no shows", will be viewed as noncompliant with treatment recommendations and may be subject to termination of services by New Day providers.
- D. If a New Day provider makes the decision to terminate services based on treatment noncompliance due to missed appointments, the provider will inform the client in writing of this decision, and provide a list of other agencies in the area that may be able to provide services.
- E. The client has the right to appeal the decision to terminate services with their assigned provider; however, the provider maintains the final decision regarding resumption or termination of services.

I have reviewed and/or received a copy of the New Day Behavioral Health Center Missed Appointments Policy and Procedure.

Client Name _____

Client/LRP Signature _____

Witness _____

Date _____

Date _____



NEW DAY BEHAVIORAL HEALTH CENTER, PC

CHILD/ADOLESCENT HISTORY FORM

To be completed by guardian. All information on this form will be confidential

Today's date: _____ If you need help filling out this form, please ask for help.

Name of Child/Adolescent: _____ Date of Birth: _____
Age: _____ Ethnic Background: _____ Medical Record #(completed by staff): _____

Who is the legal guardian/foster parent of the child?
Name: _____
Address: _____
Phone Number: _____ Cell: _____ Work: _____

Father's Name: _____ Age: _____
Address: _____
Phone Number: _____ Cell: _____ Work: _____
Occupation: _____ Employer: _____

General Health (Please circle one): Good Fair Poor

Mother's Name: _____ Age: _____
Address: _____
Phone Number: _____ Cell: _____ Work: _____
Occupation: _____ Employer: _____

General Health (Please circle one): Good Fair Poor

Other Significant Other (Stepmother, Stepfather, etc.): _____

In case of emergency please contact:
Name: _____ Relationship: _____
Address: _____
Phone Number: _____ Cell: _____ Work: _____

Where was the child born? _____
What is the name of the child's primary doctor? _____
Address: _____

Please list other persons living in the home:

Name	Age	Relationship

Is the patient experiencing any physical pain presently? Yes No
 If yes, on a scale of 1 (least) to 10 (most) how severe is the pain? _____ Where is the pain? _____
 What does the pain feel like? (i.e., sting, ache, radiate, etc.) _____

Do you have concerns about the patient's nutritional needs: Yes No

Family History

Has any blood relative of the child/adolescent had/done the following?

Please ✓ for all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Nerves | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bipolar Disease | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alcohol or Other Drug Problems | | <input type="checkbox"/> Other Emotional Problems |

Birth History

Was the pregnancy full term? (9 months) Yes No

If the child was born early, how many weeks early was the child born? _____

Place of delivery: (Circle One) Home Hospital Other: _____

Type of delivery: (Circle One) Vaginal C-Section Birth Weight: _____

Was the child cared for in the: (Circle One) Regular Nursery Neonatal Intensive Care

How long was the child in the hospital after delivery? _____

Were there any major problems during the first year of life? Please ✓ and explain all that apply.

- Hospitalizations _____
- Seizures _____
- Head Injury _____
- Other _____

Are the patient's immunizations current? Yes No

Please list all current medical problems: _____

Please list all current medications:

Medication Name Dose/Times Per Day Who Prescribed?

Medication Name	Dose/Times Per Day	Who Prescribed?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please list any past medical problems:

Please list any medication allergies:

Reactions:

Is your child allergic to Latex? Yes No

Please list any other allergies:

Reactions:

Has your child ever had surgery? Yes No If "Yes" please explain:

Grade In-school:

Name of school:

Name of home room teacher:

How many schools attended?

Has child ever repeated or failed a grade? Yes No

If yes, what grade:

What were the grades on the last report card?

Does the child have any special help or special classes at school? Yes No

If yes, please explain:

Does the child have any problems at school? Yes No

If yes, please explain:

Has the child had any of the following problems? Please v all that apply.

- Drug/Alcohol use and/or abuse
- Problems with learning
- Sleep Problems
- Anxiety/Nervousness
- Attention/Concentration Disorders
- Change in Energy Level

- Soiling pants
- Truancy
- Eating Problems
- Arrests/Legal Charges
- Excessive Worrying

- Seizures
- Nightmares
- Crying Spells
- Violent Behavior
- Self Grooming Problems

Other:

Why did you bring your child here today? Please explain in detail

How long has the problem been going on?

Has your child been in therapy before? Yes No If yes, please list:

Where	Dates from → to:	Problem	Did it Help?

Has your child ever been hospitalized because of mental health or substance abuse/use problems? Yes No

Where	Dates from → to:	Problem	Did it Help?

What do you want from therapy/treatment?

Legally Responsible Person's Signature

Date

Acknowledgment of review:

Clinician Signature

Date