DePelchin™
CHILDREN'S CENTER
and Affiliated Organizations

Confidential Child/Family History

The following information will be used to develop a treatment plan for your child, teen or family. If a question does not apply to your child, teen or family, write "N/A." If unsure how to answer, put a question mark (?) on the left, and your therapist will help you.

Child/Teen's Name: _____

Name of Person Completing Form: _____ Relationship to Child/Teen: _____

Preferred Contact Phone Number: _____

Child/Teen's Birthplace: _____ Adopted? ☐ Yes ☐ No If yes, list date of adoption: _____

EMERGENCY CONTACT(S)

Name: _____ Relationship to Child/Teen: _____

Preferred Contact Phone Number(s): _____

LEGAL PARENT/GUARDIAN(S)

Name: _____ Relationship to Child/Teen: _____

Address: _____

Home/Cell Phone(s): _____ Work Phone: _____

Are there other legal guardians or custodians? _____

List all family members living in the home: _____

Who else may bring your child/teen to therapy? _____

PHYSICIAN INFORMATION

Name: _____

Address: _____

Phone: _____ Date of Last Visit: _____

SCHOOL HISTORY

Current School: _____ Grade in School: _____

Problems at school or with grades? ☐ Yes ☐ No If yes, describe: _____

Does your child/teen have a learning disability or individual plan at school? _____

Who is your main contact at your child's school? _____

BIRTH HISTORY OF CHILD/TEEN *(Please check the appropriate box.)*

	Yes	No	If "yes," please explain:
Premature Delivery			
Breathing Problems			
Feeding Problems			
Infections			
Prolonged Hospitalization Immediately After Birth			
Other:			

During pregnancy, did the birth mother use any of the following:

	Yes	No	If "yes," please explain:
Alcohol			
Illegal Drugs			
Cigarettes			
Medications			

DEVELOPMENTAL HISTORY OF CHILD/TEEN *(Please check appropriate box.)*

Motor Skills	Early	Normal	Late	Not Yet
Sit Alone	☐ *before 6 months*	☐ *b/w 6 - 8 months*	☐ *after 8 months*	☐
Crawl	☐ *before 8 months*	☐ *b/w 8 - 11 months*	☐ *after 11 months*	☐
Walk Unassisted	☐ *before 11 months*	☐ *b/w 11 - 15 months*	☐ *after 15 months*	☐
Speech				
Coo, Make Sounds	☐ *before 11 months*	☐ *b/w 11 - 15 months*	☐ *after 15 months*	☐
Single Words	☐ *before 15 months*	☐ *b/w 15 - 18 months*	☐ *after 18 months*	☐
Words Together	☐ *before 18 months*	☐ *b/w 18 - 24 months*	☐ *after 24 months*	☐
Toilet Training				
Bowel	☐ *before 24 months*	☐ *b/w 2 - 3 years*	☐ *after 3 years*	☐
Bladder	☐ *before 24 months*	☐ *b/w 2 - 3 years*	☐ *after 3 years*	☐

Sexual Development	Yes	No	Describe:
Reached Puberty			
Sexually Active			
If female, has menstruation started?			
Has your child/teen had dating relationships?			

MEDICATION HISTORY

✓	*Please check if any*	Dosage	Prescribing Physician
	Past Medications:		
	Present Medications:		
	Drug Allergies:		

MEDICAL HISTORY

✓	*Please check if child/teen has had any of the following:*	Age	Describe
	Allergies		
	Asthma		
	Broken Bones		
	Cancer		
	Diabetes		
	Epilepsy		
	Frequent Headaches		
	Heart Disease		
	Injuries to Head		
	Sickle Cell		
	Hospitalizations		
	Other		

FAMILY HISTORY

Does your child/teen or any **biological** relative (including other children in the family) have a history of the following:

✓	*Please check if any*	Relative(s) with History
	Alcohol Abuse	
	Anxiety/Nervousness	
	Depression	

	Developmental Disorder *(e.g., autism or mental retardation)*	
	Domestic Violence	
	Drug Abuse	
	Eating Disorders	
	Hyperactivity	
	Learning Disabilities	
	Physical Violence	
	Psychiatric Problems	
	Seizures	
	Other	

Has your child/teen or family members ever been involved in abuse, neglect or with CPS?
If "yes," please describe:

_____

_____

Has your child/teen been involved in dangerous activities, harmed his or herself or others, or set fires?
If "yes," please describe:

_____

_____

Describe anything unusual or any circumstance that caused strain within the family (such as illness, conflict or separation) during your child/teen's first year of life: _____

_____

_____

Has anything happened (e.g., stressful events, major changes) that has seriously affected your child/teen's progress (such as with sleeping, eating, acting out or school)? If "yes," please describe:

_____

_____

Have any of your children lived outside the home prior to age 18? If "yes," please describe:

_____

_____

Has your child/teen or family members been involved with legal problems (e.g., guardianship or custody dispute, divorce, juvenile justice, incarceration or probation)? If "yes," please describe:

_____

_____

What types of discipline do you currently use to discipline your child/teen?_____

_____

Have you previously been to DePelchin Children's Center or received mental health services elsewhere?

If yes, what was your therapist/provider's name? _____

If prior services were received, what was the outcome? _____

What do you see as your child/teen and family's strengths? Please check all that apply.

☐ Accepts direction from caregiver
☐ Safe behavior even without close supervision
☐ Accepts responsibility for misbehavior
☐ Hangs out with pro-social peers
☐ Thinks logically
☐ Good problem solving ability
☐ Has good understanding of personal circumstances
☐ Caregiver provides stable environment
☐ Family eats dinner together
☐ Family talks about problems
☐ Caregiver is clear about behavioral expectations
☐ Caregiver adheres to a daily routine
☐ Gets along ok with teachers
☐ School grades are average or above
☐ Likes to read
☐ Likes going to school
☐ Genuinely acknowledges how own behavior has hurt or negatively impacted others
☐ Participates in religious/spiritual activities
☐ Respectful of own cultural heritage
☐ Shows respect to others
☐ Can transition from one activity to another
☐ Stays on task
☐ Participates in family-orientated activities
☐ Can be soothed and calmed when difficulties arise
☐ Is motivated to stay out of trouble
☐ Feels good about self
☐ Has a good/pleasant temperament
☐ Has healthy outlets for emotional feelings
☐ Has a positive self-perception
☐ Friendly and outgoing
☐ Good sense of humor
☐ Shows empathy towards others
☐ Participates in positive peer activities (i.e. sports)

Do family members participate in religious or spiritual practices? If "yes," please describe:

Is there any other important information on family mental health or social background that you would like us to know?

Is there any other information about your child/teen that is important for us to know?

What is your main concern for seeking services at DePelchin Children's Center?

What would you like to get out of treatment for your child/teen and for your family?

Signature of Person Completing Form **Date**

Clinician has reviewed the Confidential Child/Family History and has discussed any noteworthy information with the family.

Signature of Assigned Clinician **Date**

DePelchin™
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Coordination of Benefits

Client's Name: _____

Please fill out this form completely. Some insurance companies require this information in order to pay your claims.

SECTION A - PRIMARY INSURANCE *(Policyholder's Information)*

Name of Insurance Company: _____ Name of Policyholder: _____

Effective Coverage Dates: Start: ____/____/____ End: ____/____/____ Insurance ID Number: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Phone Number of Insurance Company: _____

Policyholder's Employer: _____

Do you have any other insurance coverage other than what has been provided to our staff?

_____ No – Skip Section B below and sign form.

_____ Yes – **Answer questions below in Section B and sign form.**

SECTION B - SECONDARY INSURANCE

Is the other insurance coverage offered through the client/parent's employer? _____ No _____ Yes

Name of Insurance Company: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Phone Number of Insurance Company: _____

Name of Policyholder: _____ Relationship of Policyholder to Client: _____

Effective Coverage Dates: Start: ____/____/____ End: ____/____/____ Type of coverage: _____ Individual _____ Family

SECTION C - NON-INSURANCE

I, _____, agree to pay DePelchin Children's Center $_____ each time services are rendered.

DePelchin Children's Center has verified my insurance benefits as follow: Deductible: _____ Copay: _____ Other: _____

I agree to pay this amount and ensure that my benefits are assigned to DePelchin Children's Center. I give permission to DePelchin Children's Center to bill my insurance directly. I understand that verification of coverage is not a guarantee of payment. If my insurance company does not pay benefits as verified, I understand that any remaining balance will become my responsibility. I understand that if I do not provide the required insurance documentation/ proof of income to DePelchin, no further appointments will be scheduled. I agree to inform DePelchin of any changes in my insurance coverage. I understand benefits will be reconfirmed by DePelchin periodically. I recognize my payment may change if new information is gained. **Payment is due at the time of service.**

Parent/Guardian Signature: _____ Date: _____

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Client Consent for Services

I, _____, hereby give my full consent for my child/teen, _____, and or myself to receive services from DePelchin Children's Center (DePelchin) until I notify DePelchin of any changes or until DePelchin determines that services are no longer necessary. If I am referring my child/teen for mental health services, I certify that I have legal responsibility for this child/teen, and I am authorized to seek treatment for him/her.

I understand that DePelchin is a training facility for licensed and unlicensed clinicians. I understand that DePelchin may request the completion of questionnaires for treatment purposes, for specific research projects conducted within DePelchin or for outcome studies. A member of the staff shall explain these questionnaires, and I have the right to choose not to participate in any research project. I understand that there is an expectation that I/we will benefit from the services provided, but there is no guarantee that this will occur. There is also no guarantee regarding the duration of treatment. I understand that my sessions may deal with sensitive and difficult topics, may elicit uncomfortable emotions and may lead to individual decisions that may be temporarily disruptive for me and my family. I understand that I will be informed if a clinical supervisor will be present during my session. I also understand that all information disclosed within my sessions is confidential and will not be revealed to anyone outside the supervision team without written permission unless required by law or necessary to comply with the requirements of accrediting agencies. Disclosure may be required by law: (1) when there is a reasonable suspicion of abuse/neglect to a child/teen, dependant or elder adult; (2) when the client communicates a threat of bodily injury to self or others or (3) when disclosure is required pursuant to a legal proceeding.

DePelchin does not provide forensic evaluation. We do not make recommendations about placement of a child/teen for custody disputes and do not provide investigation or reassessment to reach a determination about child abuse.

I understand that I have the right to refuse services and to discontinue services at any time. Also, DePelchin will discontinue services for the following reasons: 1) the goal(s) of treatment has been successfully achieved, 2) two missed appointments without 24-hour advance notification within 6 months or 3) no contact with the therapist within 30 days after last appointment. I understand that I will be financially responsible for any court reports, appearances or consultations that are required in association with the treatment received from DePelchin.

AUTHORIZATION TO SIGN ON BEHALF OF A MINOR

Where the child/teen's biological parent(s) is not married (separated, divorced, etc.) or custody is legally held by another person(s), a document showing authority to act on the child/teen's behalf is required by regulation to be filed in the client's chart.

I, _____, confirm that I am *(please check one)*:

☐ The biological or adoptive parent having legal custody generally since birth, i.e., not separated or divorced *(no need to provide legal documentation)*; or

The following must provide legal documentation:

☐ The managing conservator; or
☐ Other legal guardian and have been granted guardianship by the court or biological parents.

Please describe type: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Client (16 yrs. and older): _____ Date: _____

Witness: _____ Date: _____

I acknowledge that I have read and/or received a copy of DePelchin's "Notice of Privacy Practices."

☐ Yes *(You are welcome to ask the receptionist for a paper copy to take with you.)*
☐ No *Please describe reason:* _____

DePelchin™
CHILDREN'S CENTER
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Appointment Policy

- For your child's treatment to work, you must be actively involved. This includes keeping your appointments.

- If you are unable to keep an appointment, please call at least 24 hours in advance to re-schedule your appointment to allow other clients an opportunity to use that time. If you fail to re-schedule 24 hours in advance, your medication refill may be denied and the appointment will be documented as a no show.

- As noted in the "Consent For Services" form, DePelchin will discontinue services for the following reasons: 1) no contact with the therapist within 30 days after the last appointment (unless instructed by psychiatrist or therapist) 2) two appointments missed without 24-hour notifcation (no-show) within a six-month period. Please note: If a family's file is closed due to two no-shows, the family will not be eligible to return for six months after closure.

- Please be advised that appointments between the hours of 4:00p.m. and 7:00p.m. are limited. If you do not cancel 24 hours in advance for an appointment between those hours, you will lose that appointment time for future sessions.

- We are happy to answer any questions or concerns that you may have about appointments, prescriptions, or urgent concerns over the phone. However, we are unable to provide therapy over the phone, and calls should not last more than 10 minutes unless the therapist or physicians believes necessary in special/ urgent situations.

- Letters and documentation requested for the physician or therapist to complete need 14 days for completion and may be subject to a fee.

I have read and understood DePelchin's appointment policies.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

DePelchin™
CHILDREN'S CENTER
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Client Rights - 1

I understand that as a client of DePelchin Children's Center (DePelchin), I have the following rights:

- To the rights, benefits, responsibilities, and privileges guaranteed by the constitution and laws of the United States and Texas unless they have been restricted by specific terms of law;
- To be treated fairly with dignity and respect without discrimination;
- To receive the most appropriate services;
- To be informed of DePelchin's rules and posted hours, especially about how I am expected to behave;
- To communicate in a language that I understand;
- To give input for my own services; (To actively participate in the development and periodic review of an individual treatment and discharge plan where applicable)
- To an explanation of the benefits, effects, other choices and options, and risks of all treatment and medication (if any);
- To refuse or stop services or medication (without prejudice to other programs) and receive an explanation of possible results of refusing, unless the court orders such;
- To meet with the employees treating me and receive an explanation of their education and training, title, and responsibilities;
- To request an in-house review of care, treatment, and service plan;
- To request at my own expense, the opinion of an expert or consultant to review my services;
- To an explanation of my transfer to another employee or program within or outside of DePelchin;
- To receive information about the cost of my services;
- To refuse to participate in research and still receive services at DePelchin;
- To be asked if I agree to the use of one-way observation (watching) mirrors, video or television recordings, photography, or tape recorders before any of these are used;
- To confidential care and treatment;
- To my records being kept in a confidential manner though they are the property of DePelchin, to request access to my records or write an additional note to add in my record by following DePelchin's policies and procedures (rules) for such requests;
- To be free from mistreatment, abuse, neglect, and exploitation;
- To have physical, emotional, developmental, educational, social, religious, and spiritual needs met;
- To reasonable protection from theft or loss;
- To not be required to make public statements acknowledging my gratitude to the organization;
- To make a complaint about my services and rights without such complaints being used against me;
- To be given a copy of this statement of client rights so I may refer to it, and/or review it, and understand it;
- To an explanation of any rights that I do not understand.

DePelchin™
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Client Rights - 2

My records and/or any information conveyed by me and/or members of my family to DePelchin's personnel, will not be released without my written permission unless required by Texas Law. (Reporting alleged or suspected incidents of child abuse is mandatory under the Texas Family Code.) While the information belongs to me as a client, the record belongs to DePelchin. The information will be protected as stated in DePelchin's Notice of Privacy Practices. DePelchin will retain the record under its possession for at least the maximum number of years determined by State and Federal regulatory guidelines. Copies or transfer of the documentation within the record may be subject to a fee. My rights can only be limited on an individual basis for psychiatric or security reasons. The reasons will be written in my client record, signed, and dated by my service provider or physician and fully explained to me:

If I have a problem or concern which needs attention beyond my service provider, I may complete or request assistance in completing a Client Family Complaint Form from my therapist, from the front desk staff person, from the front desk supervisor or from a member of the Quality Improvement (QI) team. The complaint may be left with the person assisting to forward or I may request a stamped, addressed envelope and mail my complaint directly to the Quality Improvement Department at 4950 Memorial Houston, TX, 77007 (713-802-3872). I will receive feedback on my complaint within 24 hours or 72 hours (if submitted on a weekend) after the time it is received by the QI department.

If I have a complaint against a licensed physician on staff, I may contact the Texas State Board of Medical Examiners at P.O. Box 2018, MC 263 Investigations, Austin, TX 78788-2018

If I have a complaint against a Licensed Social Worker (SWA, LMSW, LCSW, LMSW-AP), I may contact the Texas State Board of Social Worker Examiners, P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540.

If I have a complaint against a Marriage and Family Therapist (LMFT), I may contact the Texas State Board of Examiners of Marriage and Family Therapists - Complaints Management and Investigative Section P.O. Box 141369, Austin, TX 78714-1369 or call 1-800-942-5540.

If I have a complaint against a licensed psychologist on staff, I may contact the Texas State Board of Examiners of Psychologists, 333 Guadalupe Ste. 2-450, Austin, TX 78701 or call 512-305-7700.

If I have a complaint against a Licensed Professional Counselor (LPC), I may contact the Texas State Board of Social Worker Examiners at P.O. Box 1411369 Autsin, TX 78714-1369 or call 1-800-942-5540.

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Client Rights Acknowledgement

- I have received a copy of DePelchin's Client's Rights.
- My rights have been explained to me.
- I have been given information regarding the reasons that services to my family or me may be involuntarily terminated by DePelchin Children's Center.
- I have been provided with information regarding DePelchin's grievance procedure and how to obtain a grievance (complaint) form.
- I have read a copy of DePelchin Children's Center's "Notice of Privacy Practices".

_____ _____
Client Date

_____ _____
Signature of Parent/Guardian Date

If no signature was obtained, Please indicate reason for not signing:

_____

_____
Employee that explained rights (if no signature obtained)

_____ _____
Witness Date

DePelchin™
CHILDREN'S CENTER
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Dear Parent or Guardian,

Attached please find an Authorization to Release Information to your Primary Care Physician. If you would like DePelchin Children's Center to notify your doctor of your services with DePelchin, please sign the first parent/guardian signature line. If you do not want your doctor notified of your involvement with DePelchin, please check the reason located in the box at the bottom of the form and sign.

Also, please note that if you want this information shared with your doctor's office, we will need a valid fax number.

Thank you!

DePelchin™
CHILDREN'S CENTER
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Authorization for Release of Information to Primary Care Physician

I _____ of _____ _____ authorize
(Parent/Guardian/Conservator) (Client) (Date of Birth)

DePelchin Children's Center, whose main office address is 4950 Memorial Dr., Houston, TX, 77007, to disclose protected health /

client information from the client record(s) of _____
(Client Name)

to my primary care physician: _____
(Name/Address of person/organization to which disclosure is to be made)

Fax #: _____ Phone #: _____

The purpose of the disclosure is for continuity of care.
The protected health/client information to be disclosed may include the following:

Discharge/Transfer Summary, Psychosocial, Psychological, Psychiatric Evaluation, Initial Assessment, Progress notes, physician notes, medication records, and treatment plans

I further acknowledge and authorize that released information may contain alcohol, drug abuse, HIV testing and results, or AIDS information.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it and in any event this authorization shall expire at the end of my service.

* I acknowledge that this authorization is voluntary.
* Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
* Information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

TO 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 without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 I, the undersigned, also understand that a copy of this signed authorization form is as acceptable as the original.

_____ _____ _____
Parent/Guardian/Conservator Relationship to Client Date

_____ _____
Client (18 years or older) Date

If you do not prefer to have you/your child's information released to the primary care physician, please check the area that applies:

____ I do not authorize the release of my information to my primary care physician for continuity of care or any other purpose.
____ I do not have a primary care physician at this time.

_____ _____ _____
Parent/Guardian/Conservator Relationship to Client Date

_____ _____
Client (18 years or older) Date

Reason the authorization was not completed: _____

_____ _____
Signature of Staff Person Completing this Section Date

DePelchin™
CHILDREN'S CENTER
and Affiliated Organizations

Authorization for:

☐ Use and Disclosure ☐ Review of Record ☐ Amendment of Protected Health/Client Information

I _____ of _____ _____ authorize
(Parent/Guardian/Conservator) (Client) (Date of Birth)

the Records Management Dept., Service Provider or Supervisor of listed client, or Designated Administrative Assistant of DePelchin Children's Center, whose main office address is 4950 Memorial Dr., Houston, TX, 77007, to disclose or obtain protected health/client information from the client record(s) of _____
(Client Name)

to/from: _____ _____
(Name/Address of person/organization to which disclosure is to be made or received from) (Relation to Client)

Fax #: _____ Phone #: _____

For service dates: _____
(Specify Dates of Service)

The protected health/client information to be disclosed includes the following:

☐ Session Notes of Counselor/Psychiatrist
☐ Discharge/Transfer Summary
☐ Initial Assessment/Evaluation
☐ Treatment Plans
☐ Psychological Evaluation
☐ Medication Records
☐ Home Study
☐ Daily Log/Case Notes (non-counseling)
☐ School Reports
☐ Appointment Dates Only
☐ Verbal Only
☐ Unrestricted (All)
☐ Other: _____

For the purpose of: ☐ Continued Care ☐ Education ☐ Legal ☐ Insurance ☐ Other: _____

I understand that I may cancel this authorization in writing that is signed and dated to the Privacy Officer at any time unless information has already been released due to it or the disclosure is required for payment to the organization. In any event, this authorization shall expire 180 days after date of signature (authorization to provide information to a contracted or coordinating service provider for ongoing service will expire after one year) unless I list another date. List date, event, or condition upon which this consent expires: _____

* I acknowledge that this authorization is voluntary.
* Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
* Information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

I also acknowledge and authorize the release of information regarding HIV or AIDS testing and test results, drug and alcohol if this information has been submitted to DePelchin.

TO 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 without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 I, the undersigned, also understand that a copy of this signed authorization form is as acceptable as the original.

_____ _____ _____
Parent/Guardian/Conservator Relationship to Client Date

_____ _____
Client (18 years or older) Date

_____ _____
Witness (Must be 18 years or older) Date

**Fees/charges that comply with all laws and regulations applicable to release of Protected Health/Client Information may be obtained as a result of the disclosure. Payment is due at time of release.*