HIGH DESERT FAMILY SERVICES LLC

OUTPATIENT INTAKE

REV. 6.21.23

1. Child's Demographic Information

Name _____ **Age** _____

SSN _____ **DOB** _____

Insurance ☐**None** ☐**Private** ☐**Medicaid-*Select*** ☐Pres ☐BCBS ☐Western Sky ☐Other

Insurance ID _____

Address: _____

City _____ **Zip** _____

Home #: _____

Caregiver Name _____ **Relationship:** _____

Legal Guardian Name: _____ **Relationship:** _____

Work #: _____ **Cell #:** _____

Email Address: _____

1st Emergency Contact: _____ **Telephone#:** _____

Home Visit Coordinator: _____ **Telephone#:** _____

School: _____ **Grade:** _____

Primary Physician: _____ **Telephone#:** _____

PCP Fax#: _____

2. Clinical Information (if known)

Diagnosis: _____

I have the following: ☐IEP ☐Developmental Screening/Assessment ☐Evaluations (any kind) ☐Other

Services Requesting: ☐Mental Health Therapy ☐Occupational Therapy ☐Behavioral Respite ☐TFC ☐Child Parent Psychotherapy (Infant Mental Health 0-5)

3. Who Referred You To Our Agency (if applicable)

Source (Name) _____

Telephone _____ Fax: _____

4. Reason for Referral (check off all that child has difficulty with below)

Gross Motor: ☐Balancing ☐Playing Safe

Fine Motor: ☐Handwriting ☐Pencil Grip ☐Cutting with Scissors ☐Using Buttons/Zippers

Visual Motor: ☐Eye-Hand Coordination

Psychosocial/Emotional: ☐Peer Interactions ☐Social Skills with siblings, parents, friends, teachers, other students in class, the lunch room

Self-Regulation: ☐Behavior Problems ☐Meltdowns/Tantrums ☐Dislike of certain clothing materials & textures

Social Skills: ☐Communication ☐Social Participation ☐Making and keeping friends ☐Starting Conversations ☐Personal Space ☐Nonverbal and verbal skills

Other: ☐Eating ☐Sleeping ☐Self-Care Skills (dressing, bathing, grooming, toileting, morning and evening routines) ☐Behavior and performance at school (in class, among peers, on playground)

☐**Mental Health/Behavioral Concerns (describe):** _____

_____

_____

_____

Individual Completing Intake **Relationship** **Date**

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REV. 6.21.23

NEEDS ASSESSMENT: Behavior/Concerns: Which behaviors have been observed in the past year?

☐inattention
☐distraction
☐impulsive
☐poor concentration
☐poor listening skills
☐difficulty staying still
☐repetitive
☐language problems
☐poor eye contact
☐avoids interaction
☐poor social skills
☐lack of interest in others
☐confused thinking
☐memory problems
☐inappropriate affect
☐bizarre behavior
☐hallucinations
☐bizarre beliefs
☐incoherent speech
☐loss of interest
☐fatigue
☐can't concentrate
☐high energy level
☐irritable
☐distractible
☐elevated, "up" mood
☐racing thoughts
☐decreased sleep
☐decreased appetite
☐other: _____

☐can't stop behaviors
☐can't stop thoughts
☐anxious if tries to stop
☐tics, grunts, sounds
☐can't control above
☐obscene language
☐screaming
☐crying
☐yelling
☐bad/scary thoughts
☐often loses temper
☐often argues
☐defies/refuses to comply
☐often angry/annoyed
☐blames others, spiteful
☐depressed mood
☐self-harming (how)
_____
_____
_____
☐nightmares
☐flashbacks
☐avoids situations
☐fearful feelings
☐feels is in danger
☐suicidal thoughts
☐suicidal behavior (what happened)
_____
_____
_____

☐destroys property
☐harms others/animals
☐runs away (from where)
_____
_____
☐set fires
☐fights with others
☐stealing
☐school truancy
☐defiant
☐sexual acting out (what)
_____
_____
☐aggression (how)
_____
_____
_____
☐substance abuse (what)
_____
_____
☐problems with the law
☐over dependent
☐anxious
☐somatic complaints
☐sleep disturbance
☐eating disturbance
☐tantrums
Duration of Tantrums:
_____

Educational Services: currently receiving:

☐regular education
☐regular education with special education consultation
☐regular education with some special education classroom time
☐special education classroom
☐day treatment school
☐home school/homebound program
☐residential school
☐hospital school program
☐charter school
☐not attending school

☐speech and language therapy
☐occupational therapy
☐physical therapy
☐adaptive physical education
☐behavior therapy
☐other:
_____

Has school assessed your child? ☐yes ☐no

If yes, what areas?

☐intelligence ☐psychological ☐social functioning

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CONSENT FOR TREATMENT & RELEASE OF LIABILITY

As a patient, you have a right to appropriate care and protection. State and Federal laws and regulations guard your confidentiality. Also have other rights, which are listed below. Read them carefully and be sure to ask your provider if you have any questions about them.

Consent to Treatment: I understand that the primary staff person(s) assigned to me will explain the nature of the assessments and treatment to be provided, the expected benefits and risks, and alternatives available. I understand that, although a reasonable standard of care will be provided, improvement, though expected, is not guaranteed. I understand that I may be contacted in the future for a follow-up interview. If I wish to withdraw from treatment at any time, the staff person will help me with an appropriate referral if I so choose.

Treatments sessions at a High Desert facility may be tape recorded for supervision and safety, which may occur via encrypted video conferencing. Tape recordings will be held completely confidential, according to state and Federal law. Tapes are for temporary use and will be erased.

Confidentiality and Release of Information: I understand that information concerning my contacts with the clinic will be held confidential among my clinical team to protect my right to privacy. I further understand that such information will not be disclosed without my written permission, or that of my legal Guardian, except under special circumstances such as:

a. If I threaten to injure myself or someone else:
b. When such information as required by law to be reported such as information regarding abuse, neglect, molestation, or exploitation of a minor, incapacitated adults, elder person 65 or older, or in the case of a court order:
c. For medical emergency, or
d. Use of pertinent parts of my medical record and /or financial record pertaining to my treatment for the purpose of quality improvement activities.

I understand and have the right to:

a. Privacy
b. Considerate care that respects my privacy and individual needs.
c. Information about my assessments and treatment.
d. Know the names and functions of everyone who takes care of me.
e. Make my care decisions before and during the course of the treatment.
f. Refuse a recommended treatment or plan of care.
g. Expect clinical staff to treat all communications and records about my care confidentially.
h. Expect continuity of care and be told about choices that are provided outside of your medical clinic.
i. Appropriate recognition and consideration of my spiritual and cultural values.
j. Review my assessment and treatment records and have information provided to me.

Crisis Intervention: In the event client's behavior escalates into a crisis situation, HDFS staff will utilize verbal de-escalation skills as per their agency approved de-escalation training. In the event client's behavior poses immediate risk of harm to self or others HDFS staff will only use agency approved non-violent physical interventions. HDFS staff may also call the HDFS on-call or 911 as deemed necessary.

OT PCP Orders: I understand that the number of weekly sessions are ordered by a PCP. If a session is cancelled, the session is to be rescheduled for the same week.

Supervision: I understand that as the responsible caregiver and/or guardian, I must stay on site during sessions. High Desert Family Services is not a drop in center.

Missed Appointments/Discharge: I understand that missing 3 consecutive sessions or 3 sessions in one month, will constitute automatic discharge from services.

Billing Insurance: I understand and consent to High Desert billing the insurance for services rendered.

Having been informed of my rights and obligations as a patient, I hereby give my consent for assessment and treatment.

_____ _____

Patient Name (signature if over age 14) Guardian/Caregiver/Patient Representative

Date:_____ Date:_____

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CONSENT FOR RELEASE OF INFORMATION

I, authorize: High Desert Family Services, LLC
1501 San Pedro Dr. NE Albuquerque, NM 87110
Tel : 505-823-4530 Fax : 505-823-4538

To DISCLOSE TO –or- OBTAIN from Previous Therapist/Provider:

- ☐ **PRIMARY CARE PHYSICIAN** _____
- ☐ **INSURANCE** _____
- ☐ **THERAPIST** _____
- ☐ **SCHOOL** _____
- ☐ **WESTRN HEIGHTS HOME VISITING PROGRAM**
- ☐ **OTHER:** _____

The following information regarding above consumer:

(check as required)

- ☐ **Presence in treatment (verification of admission/discharge dates)**
- ☐ **Diagnosis**
- ☐ **Intake and assessment (including psych/medical history)**
- ☐ **Treatment/Service Plan**
- ☐ **Discharge Summary**
- ☐ **Education/school records**
- ☐ **Screening Tools and Assessments**
- ☐ **Other *(specify)*:** _____

For the purpose of:

- ☐ **Treatment/Service Planning**
- ☐ **Ongoing treatment**
- ☐ **Insurance/benefit/funding source approval**
- ☐ **Other *(specify)*:** _____

By this release, I am not giving permission for the receiver of this information to re-disclose this information to any third party. I understand that my records are protected under state and federal confidentiality regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations. This release expires in 365 days from the date below, unless otherwise specified. I understand that I may revoke this consent at anytime and that in any event this consent expires automatically one year from the date below. I understand that this information may be transmitted via email.

_____ _____

Patient Name (signature if over age 14) Guardian/Caregiver/Patient Representative

Date: _____ Date: _____

HIGH DESERT
FAMILY SERVICES LLC

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ACKNOWLEDGEMENT OF RECEIPT OF POLICIES

I have read and/or had explained to me the following HIGH DESERT policies for services:

- Notice of Privacy Practices: I have received a copy of High Desert Family Services Notice of Privacy Practices and understand that High Desert Family Services may sometimes disclose information about me without my consent as required or permitted by law. I understand that by submitting a written request I may: receive a copy of my file; request an amendment to my file; request alternative communication methods; request limited distribution of information in my file; or obtain an accounting of disclosures. I understand that I will receive assistance as necessary to submit a written request. I understand that I can contact High Desert Family Services Privacy Office at 1501 San Pedro Dr. NE, Albuquerque, NM 87110.

- HIPAA Consent: Our Notice of Privacy Practices provides information on how we may use and disclose information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may chance. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing below, you consent to our use and disclosure of protected health information about you only for the purposes of treatment, payment, and health operations. You have the right to revoke this consent, in writing, except where we have already made disclosures based upon your prior consent. If you need assistance to make the request in writing, it will be provided to you.

- Notification of Rights: I have received a copy of High Desert Family Services Human Rights Statement and understand that I may contact my High Desert coordinator for assistance should I feel my rights are not being respected.

- Grievance and Complaint Procedures: I have received a copy of High Desert Family Services Grievance Procedure and Grievance Form and understand that I may fill out a form if my rights have been violated or if I have a complaint about the services I am receiving.

By signing below I acknowledge receipt of the High Desert Family Services Notice of Policies.

_____	_____
Patient Name (signature if over age 14)	Guardian/Caregiver/Patient Representative
Date:_____	Date:_____