OASIS Behavioral Health Services — New Patient Registration

Patient Information:							
Name:							
Date of Birth:			SSN:				
Address:		City:		State:		Zip:	
Home Phone:		Cell Phone:		Work Phone:			
Is it ok to send mail to your address? **Yes** ☐ **No** ☐			Which phone number do you prefer we use? **Home** ☐ **Cell** ☐ **Work** ☐				
Emergency contact:		Relation:		Phone Number:			
How did you find out about us?	Friend	☐	Family member	☐	Website	☐	
	Facebook/Instagram	☐	Doctor: _____	☐	Other: _____	☐	

Financially Responsible Party (if same as above, put "self"):			
Name:			
Address:	City:	State:	Zip:
Date of Birth:	SSN:		
Relationship to Patient:			
Home Phone:	Cell Phone:	Work Phone:	
Employer:	Employer's Phone:		

Primary Insurance	**Secondary Insurance**
Insurance Name:	Insurance Name:
Member/Policy I.D. #:	Member/Policy I.D. #:
Group #:	Group #:
Employer:	Employer:
Policy Holder Name:	Policy Holder Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
SSN:	SSN:
Address:	Address:

Assignment of Benefits: I hereby authorize and request my insurance to pay directly to Oasis Behavioral Health Services the amount due for services rendered to me or my dependent.

Release of Information: I authorize the release of any medical information necessary to process this claim. This may include, but not be limited to, an outpatient treatment summary describing prognosis, frequency of treatment, and/or medications prescribed. This is a continuing consent for release of psychotherapy and/or substance abuse records for the duration of my treatment or until rescinded in writing.

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Oasis Behavioral Health Services. I understand Oasis Behavioral Health Services may take legal action to obtain payment if my account is in arrears and I have not made prior arrangements for payment. I will be responsible for any fees involved in the collection of this debt if sent to an outside collection agency or attorney. These fees will be added to my total amount due.

Patient Signature:	Date:
Parent/Guardian Signature:	Date:
Witness Signature:	Date:

OASIS
Behavioral Health Services

Notice of Privacy Practices

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the notice you will find how health information about you (as a patient of this practice) may be used and disclosed as well as how you can receive access to your health information.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the confidentiality of your health information as required by law. We are aware that some of these laws may seem complicated, so feel free to ask any of our staff if you require clarification.

Uses and Disclosures with Neither Consent nor Authorization

State law, HIPAA regulations, and our code of ethics specifically guarantee your privacy as our patient. However, there are some situations in which confidentiality cannot be guaranteed. The following are circumstances that may require us to use/disclose your health information **without** a signed release:

- Child and Elder Abuse: We must report any abuse, neglect, or exploitation to the proper authorities.
- Serious Threat to Health or Safety: We must notify the appropriate persons if we believe a patient is an imminent danger to themselves or others.
- Judicial or Administrative Proceedings: Your information may become subject to disclosure if any of the following apply: you become involved in a lawsuit, we receive a subpoena or court order, if you are an inmate or under custody of a law enforcement officer, or if requested by federal officials for intelligence and national security.
- Member/ Veteran of U.S. or Foreign Military Forces: If required by the appropriate authorities.
- Workers Compensation, Insurance, or Managed Care Program: Your contract with any of these programs may permit administrative access to your records.

Client's Rights and Clinician's Duties

- Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or location (e.g. sending your bill to a alternate address because you prefer a family member not know you come here).
- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction that you request.
- Right to Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your clinician. Under certain circumstances your request may be denied by your clinician, who will discuss their decision with you.
- Right to Amend: To request an amendment, you must submit your request in writing to your clinician as well as provide them with information that supports your request.
- Paper Copy: You have the right to obtain a paper copy of this notice from our office upon request at any time.
- Authorization for Other Uses and Disclosures: We will obtain your written authorization for any uses and disclosures that are not identified by this notice or permitted by applicable law.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Shawn R. Cade, P.O. Box 219 Barboursville, WV 25504. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

BY SIGNING THIS FORM YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____	_____
Patient Signature	Parent/Guardian Signature
_____	_____
Witness Signature	Date

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_____ Patient Signature

_____ Parent/Guardian Signature

_____ Witness Signature

_____ Date

OASIS
Behavioral Health Services

Informed Consent for Telehealth Services

If my treatment provider has recommended telehealth services, I understand and recognize the risks, benefits, and alternatives to the use of the telehealth platform. I understand the following:

- I understand I have the option to withhold consent at this time or to withdraw this consent at any time, including anytime during a session, without affecting the right to future care, treatment, or risking the loss or withdraw of any program benefits to which I would otherwise be entitled.

- I understand the benefit of utilizing the telehealth platform, for I will be able to participate in telehealth services in a safe secure manner while limiting the barriers of transportation and local access to care.

- I understand the potential risks to utilizing the telehealth platform, for there could be partial or complete failure of the equipment being used which may result in the provider's inability to complete the evaluation or treatment services.

- I understand there are no permanent video recordings of my sessions unless I give written consent to be recorded for training or therapeutic purposes.

- I understand that I have HIPAA protections equal to the protections that exist as an in-person service recipient.

- Dissemination of client identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my consent.

- I understand there are circumstances under which online behavioral health services are not the appropriate or most effective treatment. I agree that my provider and I may determine that certain services are inappropriate under this medium.

- If I am having medical, psychiatric, or other critical issues which require face-to-face intervention, it is my responsibility to seek that level of help. **IF I AM CURRENTLY CONSIDERING OR THREATENING SUICIDE OR ANY FORM OF HARM TO MYSELF OR OTHERS, I TAKE FULL RESPONSIBILITY FOR SEEKING APPROPRIATE HELP IMMEDIATELY BY CONTACTING 911 OR GOING TO MY LOCAL EMERGENCY CENTER.**

- I understand I can request a printed copy of the *Terms of Use and Notice of Privacy Policies* regarding this treatment platform.

- [For services provided to home computers only] I take full responsibility for the security of treatment-related correspondence and records on any computer that I may use for these purposes. Correspondence or other information sent to me by my provider may be held liable for any breach of confidentiality regarding electronic or paper records which occur as a result of my failure to secure the computer through which I am receiving services.

Having read and understood, I consent to telehealth services. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered.

Patient Signature	Parent/Guardian Signature
Witness Signature	Date

OASIS
Behavioral Health Services

Consent to Treat a Minor

I,_____, custodial parent/legal guardian of
(parent/guardian name)

_____, age_____authorize:
(name of child)

Oasis Behavioral Health Services, LLC to assess and treat my child in an outpatient psychological, counseling, and psychiatric setting. I agree to take part in the counseling process as needed, and I understand the format of counseling may include any combination of the following: individual sessions with minor child, family sessions, and sessions with the parent(s). The treatment may also include recommendations for medications. If this occurs, you will be fully advised so that you can make an informed decision about this mode of treatment.

Parent/Guardian Signature:_____**Relationship to Minor:** _____

Signature of Minor:_____**Date:** _____

Signature of Counselor:_____**Date:** _____

Child Custody

Has custody of the child ever been determined by a court ruling? **Yes**☐ **No**☐

If yes, please provide the front office staff or your clinician with a court order or guardianship documentation.

Child Custody Payment Agreement

In the case of a divorce where there is a minor child receiving service from **Oasis Behavioral Health Services, LLC,** we must have one parent act as the legal guarantor for payment of services.

My signature and contact information below acknowledges that I am responsible for the full payment of all fees for services provided by Oasis Behavioral Health Services (less any amount paid by a third party payer).

_____
Print name

_____ _____ _____
SSN Date of Birth Phone Number

_____
Address City State Zip

_____ _____
Signature Date

For Office Use Only:
Date reviewed: _____
Clinician's Initials: _____

Child Developmental and Psychosocial History

(12 and under)

To be completed by a Parent/Guardian

Please complete **all** questions to the best of your ability and as honestly as you can. Doing so will help the therapist obtain a complete and accurate profile of your child to assist them in helping him/her as quickly and efficiently as possible. If there is a question that does not pertain to you, just write N/A (not applicable) in the space provided. Your therapist will review this questionnaire with you to assure accuracy and to elaborate where indicated.

If you are uncomfortable with answering any of the following questions, simply leave it blank and speak to your child's therapist about it.

All information that you share with this office is **CONFIDENTIAL** and will not be shared with anyone outside of this office without your written permission, a court order, in the event the child is harm to themselves or others or the child is being abused.

General Information	
Child's name:	
Date of Birth:	Gender:

Legal Guardian
Legal Guardian's name:
Phone Number:
Address:
Who does the child live with?

Parents	
Mother's name:	
Date of birth:	Phone number:
Occupation:	Highest level of education:

Father's name:	
Date of birth:	Phone number:
Occupation:	Highest level of education

Marital status of parents: Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:_____

If parents are separated/divorced, how old was the child when this occurred? _____ _____

Step-Parents	
Step-mother's name:	
Date of birth:	Phone number:
Occupation:	Highest level of education:

Step-father's name:	
Date of birth:	Phone number:
Occupation:	Highest level of education:

Presenting Problems

Please list your current concerns about your child and how long they have been occurring:
1.
2.
3.
4.

What goals would you like to see your child achieve as a result of therapy?
1.
2.
3.
4.

Please list any stressors your child has experienced in the last three years:

What type of discipline is used in the home?
Has this been effective?

What are your child's strengths?
What are your child's weaknesses?

What types of activities and hobbies does your child enjoy?

With whom does your child most often play?

School Information

Current school:	Grade level:
Current teacher:	School counselor:

How is your child's relationship with their current teacher? **Good** ☐ **Fair** ☐ **Poor** ☐

Other adults at school that your child trusts (nurse, counselor, principal, etc.,):

Has your child repeated any grades? **Yes** ☐ **No** ☐

If yes, which one(s)?

Has your child's performance at school changed as he/she has gotten older? **Yes** ☐ **No** ☐

If yes, how?

Are you satisfied with your child's grades at this time? **Yes** ☐ **No** ☐

Has your child had psychological testing from the school ? **Yes** ☐ **No** ☐

If yes, when?

Does your child have any special education needs that require assistance? **Yes** ☐ **No** ☐

If yes, please explain?

Does your child have any specific fears related to school? **Yes** ☐ **No** ☐

If yes, explain?

Please check below any school problems your child has:

	Never	Always	Recently		Never	Always	Recently
Reading skills	☐	☐	☐	**Working too quickly**	☐	☐	☐
Math skills	☐	☐	☐	**Conflict with teachers**	☐	☐	☐
Social Studies	☐	☐	☐	**Not following rules**	☐	☐	☐
Science	☐	☐	☐	**Interrupting**	☐	☐	☐
Handwriting	☐	☐	☐	**Fighting**	☐	☐	☐
Not wanting to go to school	☐	☐	☐	**Getting out of seat**	☐	☐	☐
Staying on task	☐	☐	☐	**Concentration issues**	☐	☐	☐
Completing class work	☐	☐	☐	**Following directions**	☐	☐	☐
Working too slowly	☐	☐	☐	**Organizing materials and tasks**	☐	☐	☐

Developmental History

During pregnancy, did mother experience any of the following: (Please check all that apply)			
Excessive vomiting	☐	Toxemia (fluid retention)	☐
Hospitalization for complications	☐	Illness or operations	☐
Excessive spotting or blood loss	☐	Smoking during pregnancy	☐
Threatened miscarriage	☐	Drinking during pregnancy	☐
Infection(s)	☐	X-rays during pregnancy	☐

Were any medications taken during pregnancy?	**Yes** ☐	**No** ☐
If yes, please list:		

Was the pregnancy full term?	**Yes** ☐	**No** ☐
If no, list length of pregnancy:		

Were there any additional pregnancy or delivery complications?	**Yes** ☐	**No** ☐
If yes, please describe:		

Any birth defects?	**Yes** ☐	**No** ☐
If yes, please list:		

Describe your child's personality during infancy:

Did your child have any problems with sleep as an infant?	**Yes** ☐	**No** ☐
If yes, please describe:		

Did your child have any issues with these developmental milestones: (Please check all that apply)			
Smiling	☐	Potty training	☐
Crawling	☐	Riding tricycle/bicycle	☐
Standing without support	☐	Dressing self	☐
Speaking first words (other than "mama, dada")	☐	Saying alphabet	☐
Saying phrases	☐	Learning to read	☐

Did your child have any problems with motor coordination?	**Yes** ☐	**No** ☐
If yes, please describe:		

Medical History

Who is your child's primary doctor?
Name:
Phone number:

List any medications your child is currently taking, including dosage. (Continue on back of packet if needed)

Medication: (ex. Adderal)	**Dosage** (ex. 2mg)	**Frequency** (ex. 2x daily)	**Prescribed By** (ex. Dr. Ross)

Child's history of and current illnesses/problems (Please check all that apply):

	Currently	**Past**		**Currently**	**Past**
Suicidal remarks/attempts	☐	☐	Emotional outbursts	☐	☐
Attention Deficit Disorder	☐	☐	Problems getting along	☐	☐
Prone to violence	☐	☐	Injuries	☐	☐
Self harm	☐	☐	Excessive bed-wetting	☐	☐
Eating disorders	☐	☐	Threatens others	☐	☐
Surgery	☐	☐	Sleeping issues	☐	☐

Please check any of the following which are [or have been] a problem:			
Unsatisfactory relationships	☐	Religious abuse/addiction	☐
Compulsive sexual acts	☐	Compulsive spending	☐
Eating disorder	☐	Compulsive overeating	☐
Dependent relationship(s)	☐	Explosive temper	☐
Obsessive/compulsive behaviors	☐	Tobacco addiction	☐
Sexual offender	☐	Caffeine addiction	☐
Physically abused	☐	Victim of sexual abuse	☐
Parent with substance use disorder	☐	Neglected as a child	☐

Family History

List any medical problems occurring in the child's immediate and extended family:

List any learning disabilities or school problems occurring in the child's immediate and extended family:

List any psychiatric problems in the immediate or extended family (substance abuse, anxiety, depression, mood swings, marital conflicts, etc.,)

Please list your child's birth/immediate family (eg. siblings, step-siblings, grandparents)

Name	Relation to Child	Age

Thank you for taking the time to complete this packet! We look forward to working with you and your child!
Please use this section if you have anything that you would like to discuss that was not covered in this packet or if you need to list any additional medications!

Guardian's Signature _____ **Date** _____