Pediatric Associates of University of Iowa Stead Family Children's Hospital

Monday – Thursday 7:00 am – 8:00 pm Friday 7:00 am – 5:00 pm Saturday 8:00 am -12:00 pm Sunday 12:00 pm – 4:00 pm

1360 N. Dodge Street
Iowa City, IA 52245
(319) 351-1448

2593 Holiday Rd.
Coralville, IA 52241
(319) 339-1231

Dear Parent,

Thank you for your interest in seeking behavioral health services through Pediatric Associates. Before your first appointment you will need to fill out the forms in this packet: *Understanding Mental Health Coverage, Outpatient Services Agreement/Informed Consent, and New Patient Information*.

Please review and complete these forms and bring them to your first appointment with Dr. Susan VanScoyoc, our child psychologist. **All appointments are held at our Iowa City location at the address listed above**. If they are not completed, you will have to do them during your appointment time, shortening the amount of time Dr. VanScoyoc will have to hear your concerns.

It is very important that you contact your insurance provider about your specific mental health coverage before your first appointment with Dr. VanScoyoc. Mental health services are often not covered with the same benefit structure as medical care. If you have any questions about billing or insurance, please contact our business office at (319) 351- 1448.

Any questions about treatment or the Outpatient Services Agreement can be discussed with Dr. VanScoyoc at your first appointment. The first appointment is typically 60 minutes. The time will be spent with you, your child, and/or both of you together depending on your concerns and the age of your child. **Please note that if you arrive more than 15 minutes after your scheduled appointment time, Dr. VanScoyoc may not be able to see you and you may be asked to reschedule the appointment.** Please call if you are running late or if you will be unable to attend an appointment.

We look forward to assisting your family with your psychological needs!

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Understanding Mental Health Coverage: Action Required

Dear Parent,

This is to inform patients (or the patient's parent, legal guardian or authorized representative) that it is your responsibility to provide Pediatric Associates with correct insurance information for your mental health coverage.

Your mental health coverage may not be provided by the same entity as your medical care and thus may not cover our psychologist, Dr. Susan VanScoyoc, the same way it pays your child's other healthcare providers.

Although most insurance companies reimburse for mental health or behavioral health services, coverage for these benefits is different for each company and plan. It is your responsibility to consult your insurance carrier to determine coverage**. We recommend that you contact your insurance carrier <u>in advance of your appointment</u> to ask specifically about your plan's mental health coverage, such as any need for preauthorization, number of sessions allowed, types of therapy permitted, and diagnoses not covered by your plan, as well as co-pay amount and deductible for mental health services.** If your policy limits the number of mental health visits within a given year, you are responsible for keeping track of these visits, as oftentimes other providers (e.g., psychiatry visits) are included in this number of sessions. A fee schedule for psychology services can be found on our website at www.pedsic.com. There may be more than 1 unit charged, depending time spent by the psychologist.

Payment for all mental health care services will be your responsibility. Pediatric Associates will submit insurance claims on your behalf. However, the insurance contract is between you and the insurance company and it will be your responsibility to ensure payment.

<u>Failure to contact your insurance prior to your appointment and receive prior authorization will result in 100% patient responsibility.</u>

By signing this document you agree to all policies and procedures and will provide up to date insurance information. You also state that all information provided is true and complete. Any errors or omissions may result in a denial or nonpayment from the insurance company. _____ (Please initial here stating you have read and understand.)

Patient's Name:_____ Date:_____

Mental Health Insurance Carrier:_____

Policy #:_____ Authorization #:_____

Signature:_____Date:_____

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Outpatient Services Agreement/Informed Consent for Psychological Assessment and Treatment: Signature Required

This agreement pertains to services provided by Pediatric Associates of the University of Iowa Children's Hospital

CONFIDENTIALITY

Communication between a patient and psychologist are protected by law. Written or verbal information regarding assessment or treatment at this clinic is provided to outside individuals/agencies only after your written permission to specifically release Mental Health information is obtained. In order to provide integrated care, it is generally our practice to consult with your child's medical provider at Pediatric Associates as needed regarding our work together. Electronic medical records are shared with your medical provider but your child's behavioral health records are kept confidential.

There are a few exceptions to confidentiality that are required by law:

1. All Iowa citizens are required to report any reasonable belief that a child or vulnerable adult has been subjected to abuse or neglect.
2. Health care providers are obligated to act if a patient is in danger or self-harm or of harming another person.
3. Disclosure of information is court-ordered.

You also have the right to confidential communication. We use the address and phone number(s) you provide to us to contact patients and leave messages. Please provide us with written instructions if you prefer to be contacted a different way. Additionally, there may be times when it is necessary for us to talk to you on a cell phone. We understand that these communications are not always secure and thus, if you do not want to be contacted via cell phone, please let us know. You can find the procedure for restricting contact information in the Notice of Privacy Practices at www.pedsic.org.

WHAT TO EXPECT IN MENTAL HEALTH TREATMENT

Pediatric Associates employs an active, practical, and evidence-based approach to treatment. During the first one or two sessions, an intake evaluation is conducted and you are provided with initial recommendations. Based on your presenting concerns and goals, additional psychological assessment and therapy services are determined. In general, regular and consistent attendance to session by both the parent(s) and child or adolescent is necessary for psychological treatment to be effective. If you are unable, for any reason, to attend regularly we may choose to discontinue treatment. Also, if the psychologist determines she is not qualified to treat your child's mental health problems at any point during treatment, she will refer you to other providers in the community.

CANCELLED/MISSED APPOINTMENTS

We request that you contact us at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule an appointment. Fewer than 24 hours notice on 2 or more occasions may require us to discuss alternative plans for your child's behavioral health needs.

Please note that my schedule can be filled quickly and for several weeks past your scheduled appointment time. As a result, you may not always have the ability to reschedule easily for the same week in which you cancelled or missed an appointment.

EMERGENCIES

If you are experiencing an emergency situation in which someone's physical safety is threatened, you should call 911 or immediately go to the nearest hospital emergency room. If the situation does not involve safety, you can call the main Pediatric Associates number in Coralville at 319-339-1231 during business hours (7:00 am -5:00pm) and leave a message for the psychologist. She will return your call as promptly as possible. Calls on Friday will not be returned until Monday or later. After hours, please call 319-356-0500. The after-hours professional will contact a medical provider, if necessary.

FINANCIAL TERMS & INSURANCE

Please review the Understanding Mental Health Information form in this packet. It describes your responsibilities regarding the financial obligations of seeking psychological treatment through Pediatric Associates.

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment for all health care services provided through Pediatric Associates, even though I may have health insurance. I hereby guarantee payment of all charges and finance charges incurred for the account of the name patient. I hereby authorize payment if insurance benefits directly to Pediatric Associates of the University of Iowa Children's Hospital.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Pediatric Associates to release all treatment information of other information requested by my health insurance carrier or any other third party payers to process claims for this account. I authorize Pediatric Associates to contact my insurance company or health administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Pediatric Associates.

NOTICE OF PRIVACY PRACTICES

When you joined Pediatric Associates for the healthcare of your child, you were provided with a document that discusses how your private information is used and disclosed--the Notice of Privacy Practice. All of those practices also apply to the psychological services you are currently seeking for your child. By signing below you are acknowledging receipt and understanding of these policies. If you would like to review the most recent version of the policy, it can be found on our website at www.pedsic.org or a paper copy can be provided to you at any Pediatric Associates office. If you need clarification on any topic, please be sure to ask your provider or the privacy officer listed on the document.

CONSENT TO TREATMENT

I consent to behavioral health care delivered through Pediatric Associates and acknowledge that no guarantees have been made to me as the result of diagnoses, treatment, or evaluations. I understand that while psychological services are designed to be helpful, they may be difficult or emotionally uncomfortable. I have read and understand all of the above information and agree to the provisions as described. I have had an opportunity to ask questions about the terms of this agreement. In sum, I authorize and request that the psychologist/therapist provide services (e.g., psychological evaluations, treatments, diagnostic procedures) for my child or legal ward.

_____ _____

Patient Name – Printed Date of Birth

_____ _____

Parent of Legal Guardian Signature (for patient under age 19) Date

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New Patient Information-Behavioral Health

Date **_____**

Child's Name: _____Nickname: _____

Age: _____ Date of birth: _____ Gender: _____

Address: _____

Best contact phone number(s): _____

Who referred you for behavioral health services? _____

Child's Primary Care Physician: _____

Person completing this form: _____

Relationship to child: _____

About Your Child

What are your primary concerns about your child? (Reason for referral)

_____

_____

What would you like to achieve by seeking treatment for your child?

_____

_____

Have you sought help for this (or other mental/behavioral issues) before? If yes, please provide details on who saw your child, when, for how long, and any diagnoses or medications given:

_____

_____

_____

_____

If you feel previously treatment was not effective, please explain why: _____

_____

Growth and Physical Development Information

Birth Weight _____ Uncomplicated Pregnancy Yes No
If no, what types of complications? _____
Use of substances/medications during pregnancy? No Yes (type)_____
Normal labor and delivery Yes No
General infant development(1st year): Good Fair Poor
If poor, what types of problems (e.g., colicky, poor feeder, etc.) _____

Please indicate when your child achieved the following activities: (approximate age when skill was acquired or indicate 'normal' or 'delayed'):

Sat Alone _____ (average 6 to 8 mos.)
Crawled _____ (average 9 mos.)
Walked _____ (average 12 to 18 mos.)

Fed Self _____ (average 10 to 12 mos.)
Spoke Words _____ (average 10 mos.)
Toilet Trained _____ (average 2 to 4 yrs.)

Does your child have any physical health problems that may interfere with normal functioning (vision, hearing, motor, chronic illness)? No Yes _____

Please indicate if your child ever had any speech, occupational, or physical therapy and for what reason:
_____

Is your child currently taking any medications? No Yes
If yes, what kind and how long has child taken each medication? _____
Does your child have any medication allergies? No Yes: _____

Has your child had any seizures, known heart problems, or head trauma? No Yes_____

Has your child had any hospitalizations or surgeries? No Yes: _____
Does your child experience pain such as headaches or stomachaches or a regular basis? _____

Sleep Habits:

Do you and your child experience sleep-related conflict? Never Rarely A few times per week Nightly

What is the reason for conflict (e.g., out of bed, won't sleep in own bed, trouble falling asleep, trouble staying asleep, up too early, etc.)? _____

On most nights, how many hours does your child sleep? _____

If your child is an adolescent, do you both agree on what their sleep routine should be?

_____

Other concerns? (nightmares, bedwetting, sleepwalking) _____

Nutrition/Exercise

Do you and your child experience mealtime/exercise conflict? Never Rarely A few times per week Daily

If yes, what is the reason for concerns/conflict? (e.g., picky eater, overeats, won't sit still, etc.)

_____

General Behavior Information
Which of the following are currently a problem for your child?

	Never	Sometimes	Often (a few times per week)	Always (daily)
Won't mind				
Impulsive				
Too active				
Short attention span				
Lying				
Destroys property				
Stealing				
Cruel to others				
Cruel to animals				
Runs away				
Odd behaviors: _____				
Self-harm (cutting)				
Other:				

General Mood Information

Which of the following are currently a problems for your child?

	Never	Sometimes	Often (a few times per week)	Always (Daily)
Angers easily				
Cries easily				
Anxious				
Sad				
Irritable				
Excessively negative				
Moody				
Perfectionist				
Preoccupied with: _____				
Poor self-calming skills				
Emotional response is out of proportion to situation				
Other:				

Has there been a noticeable change in your child's mood/behavior over the past 6 months? No Yes

If yes, what might be the cause? _____

Has your child ever made attempts or statements of self-harm or harm to others? If yes, please provide examples and timeline for events (e.g., within past week, past month, past year, etc.): _____

Social Development

What concerns do you or any other caregivers have about your child's social behavior (sharing, empathy, sensitivity, reading social cues)?

_____

What concerns do you have about your child's social relationships (shy, lacks friends, bossy, bully, has been bullied, lacks interest in others)?

_____

What are your child's social interests/activities (reading, sports, youth groups, crafts)?

_____

What are your child's personal strengths?

_____

Impairment Summary:

How much does your child's problems impact:

Self Esteem	Not at all	Slightly	Moderately	Definitely/Almost Daily
Relationship with you/parents	Not at all	Slightly	Moderately	Definitely/Almost Daily
Relationship with siblings	Not at all	Slightly	Moderately	Definitely/Almost Daily
Overall family functioning	Not at all	Slightly	Moderately	Definitely/Almost Daily
Academic Progress	Not at all	Slightly	Moderately	Definitely/Almost Daily
Peer Relationships	Not at all	Slightly	Moderately	Definitely/Almost Daily

Your Child's Family

Parent/Guardian name: _____ Parent/Guardian name:_____
Biological Step Adoptive Foster/Guardian Biological Step Adoptive Foster/Guardian

Place of Employment_____ Place of Employment: _____
Occupation _____ Occupation _____

Child lives with: Both parents One parent Parent/Stepparent Visitation Arrangement-parents live apart

Other members of the household (*for example: siblings, step-siblings, niece/nephew, foster children)*:

Name	Age	Sex	Relation to patient
_____	___	___	_____
_____	___	___	_____

Other regularly involved adults (*for example: grandparents, non-custodial parent/step-parent)*: _____
_____

Family stressors over the past 24 months (circle all that apply): Major changes in household (birth/death/divorce/move) Financial Marital conflict Domestic violence Substance abuse Parenting conflict Physical or mental health of parent/s Physical or mental health of sibling/s Legal Problems Parental Job Demands: Other: _____

Is there a family history (grandparents, uncles, aunts, cousins, parents, siblings) of any mental health disorders, diagnosed or not (mood, learning, attention, substance use, autism, schizophrenia)?

Immediate family: _____

Extended family: _____

What **social resources** are available to your family (circle all that apply)?

Significant other Extended family Friendships Community Educational network Religious community Other mental health care providers Other: _____

School Information

Name of Daycare/School: _____

Current grade level: _____

Teacher(s) name(s): _____

_____

Current academic grades: _____

…If your appointment time is during the summer months…

School attended last year:_____

Grade level entering next year: _____

Grades last reporting period: _____

Are there problems at school with any of the following (check those of concern):

____ Behavior ____ Learning _____ Peers ____Attendance _____Homework

Has your child ever been suspended, expelled, or retained in a grade? No Yes

Have you had extra conferences with school authorities for behavior/learning problems? No Yes
What do they suggest is needed to help your child? _____
_____

Do you agree? Or what are your ideas about what is needed?
_____

Has your child ever received any type of educational programming (e.g., IEP, 504 Plan (Accommodations, Speech Services, Resource Room, Behavior Disorders Class)? No Yes
If yes, please explain_____

If an adolescent, is he or she employed and where? _____