CHILD/ADOLESCENT HEALTH HISTORY - MEDICAL

Please explain any selected response(s) on the lines following the selection.

Eyes, Ears, Nose, Throat

- [ ] None Reported
- [ ] Glaucoma
- [ ] Ear/Hearing Problems
- [ ] Eye/Vision Problems
- [ ] Throat Problems
- [ ] Other
- [ ] Nose Problems/Nosebleeds

Musculoskeletal

- [ ] None Reported
- [ ] Arthritis
- [ ] Gout
- [ ] Bone/Joint Difficulty
- [ ] Back Pain/Injuries
- [ ] Other

Blood/Lymphatic System

- [ ] None Reported
- [ ] Anemia (Low RBC Count)
- [ ] Other
- [ ] Bleed Easily
- [ ] Bruise Easily

Circulatory/Cardiac Systems

- [ ] None Reported
- [ ] Coronary Artery Disease
- [ ] Angina
- [ ] Rheumatic Fever
- [ ] Other
- [ ] High Blood Pressure
- [ ] Heart Murmur
- [ ] Abnormal EKG
- [ ] Irregular Heart Beat
- [ ] Chest Pain
- [ ] Heart Attack

Endocrine System

- [ ] None Reported
- [ ] Diabetes
- [ ] Excessive Urination
- [ ] Menopause
- [ ] Other
- [ ] Thyroid Disease
- [ ] Weight Gain
- [ ] Menopause Problems
- [ ] Excessive Thirst
- [ ] Weight Loss
- [ ] Erectile Dysfunction
### Gastrointestinal System

- [ ] None Reported
- [ ] Difficulty Swallowing
- [ ] Diverticulitis
- [ ] Pancreatitis
- [ ] Hepatitis A
- [ ] Hemorrhoids/Rectal Disease
- [ ] Vomiting
- [ ] Diverticulosis
- [ ] Stomach Pain
- [ ] Liver
- [ ] Ulcer
- [ ] Hepatitis B
- [ ] Reflux
- [ ] Diarrhea
- [ ] Other

### Genital/Urinary System

- [ ] None Reported
- [ ] Urinary Tract Problems
- [ ] Sexual Difficulties
- [ ] Prostate
- [ ] Sexual Transmitted Disease
- [ ] Infections
- [ ] Other

### Nervous System

- [ ] None Reported
- [ ] Seizures/Epilepsy
- [ ] Loss of Coordination
- [ ] Head Injury
- [ ] Black-Outs
- [ ] Headaches
- [ ] Speech Problems
- [ ] Spinal Cord Injury
- [ ] Dizziness
- [ ] Tremors
- [ ] Loss of Feeling in Hand/Foot
- [ ] Sleep Problems
- [ ] Other

### Respiratory System

- [ ] None Reported
- [ ] Difficulty Breathing
- [ ] Pneumonia
- [ ] Frequent Coughing
- [ ] Asthma
- [ ] Tuberculosis/Results
- [ ] Other

### Integumentary System

- [ ] None Reported
- [ ] Boils
- [ ] Psoriasis
- [ ] Other
- [ ] Itching
- [ ] Rashes
- [ ] Acne
- [ ] Eczema

### Additional Questions
Have you ever had any surgeries? □ Yes □ No

Have you had cancer? □ Yes □ No

Any abnormal lab tests/results? □ Yes □ No

Have you ever had a head injury? □ Yes □ No
If yes, did you lose consciousness/have a concussion? □ Yes □ No

*=For Females Only:
*Any problems with menstruation? □ Yes □ No
*Do you plan to become pregnant? □ Yes □ No
*Do you use birth control? □ Yes □ No
*Any history of pregnancy, miscarriage or terminations? □ Yes □ No

CHILD/ADOLESCENT HEALTH HISTORY - FAMILY
If yes, please explain on the lines following selection (family member, health/psychiatric problem)

Has anyone in your family had health problems? □ Yes □ No

Has anyone in your family had a psychiatric problem? □ Yes □ No

Has anyone in your family had substance-abuse problems? □ Yes □ No

CHILD/ADOLESCENT HEALTH HISTORY - PAIN
If yes to either, please explain (on a scale of 1 to 10, 1=lowest, 10=highest, what is your score?)

Are you experiencing any pain right now? □ Yes □ No

Do you experience any chronic untreated pain? □ Yes □ No

CHILD/ADOLESCENT HEALTH HISTORY - DEVELOPMENTAL HISTORY
Birth Father's Information: □ Unknown
   First Name: ___________________________ Last Name: ___________________________ Age at Birth: ___

Birth Mother's Information: □ Unknown
   First Name: ___________________________ Last Name: ___________________________ Age at Birth: ___

Biological/Birth Parent's Marital Status (at birth and current): □ Unknown

Birth Certificate Information (parents identified on birth certificate): □ Unknown

Location of Birth (name of center/facility, home-birth): □ Unknown

Place of Birth (city, state, province, county): □ Unknown

Pregnancy
Was this a planned pregnancy? □ Yes □ No □ Uncertain
Was this a wanted pregnancy? □ Yes □ No □ Uncertain
Was prenatal medical care provided? □ Yes □ No □ Uncertain
Were there health problems/illness during pregnancy? □ Yes □ No □ Uncertain
Were there medical operations/procedures during pregnancy? □ Yes □ No □ Uncertain
Were there other complications/problems during pregnancy? □ Yes □ No □ Uncertain

Prenatal Exposure (check all that apply)
□ None Reported □ Lead/Mercury □ Nicotine
□ Alcohol □ Medications (over-the-counter) □ Poisons
□ Caffeine □ Medications (prescription) □ Toxic Chemicals
□ Illicit Drugs □ Other Dangerous Substances

Delivery
Pregnancy Length: _____ Weeks   Labor Length: _____ Hours
Birth Size: _____ lbs _____ oz.   Birth Weight: _____ Inches

Complications/Medical Factors
□ None Reported   □ Breeched Birth   □ Induced Labor
□ Anesthesia Used   □ Caesarean Delivery   □ Premature Birth (incubator)
□ Breathing Problems   □ Forceps Used   □ Supplemental Oxygen
□ Bilirubin Lights   □ Other Complications   □ Other Medical Factors
Early Achievements/Milestones (If early or delayed, please explain on the lines following this section)

Turning over on his/her own   Age achieved: ______ months  □ Unknown
Sitting up on his/her own    Age achieved: ______ months  □ Unknown
Crawling                     Age achieved: ______ months  □ Unknown
Standing on his/her own     Age achieved: ______ months  □ Unknown
Walking on his/her own      Age achieved: ______ months  □ Unknown
Speaking first word         Age achieved: ______ months  □ Unknown

Feeding & Weaning
In infancy/childhood, was the child breast-fed? □ Yes  □ No  □ Uncertain
In infancy/childhood, was the child bottle-fed? □ Yes  □ No  □ Uncertain
Complications/difficulties:  □ Unknown

Other problems in infancy:  □ Unknown

Self Regulation
When did day-time toilet training occur? ______ Months
When did night-time toilet training occur? ______ Months
After toilet trained, did bed-wetting continue to occur? □ Yes  □ No  □ Uncertain
   If so, when did it stop? ______ Months
After toilet trained, did bed-soiling continue to occur? □ Yes  □ No  □ Uncertain
   If so, when did it stop? ______ Months

Physical Injuries & Significant Stressors (If “yes” to either, please explain on the lines following this section)
Has the child experienced significant injuries (head injuries, loss of consciousness, etc.)?
□ Yes  □ No  □ Uncertain

Were there any major changes/stressors during patient’s infancy/childhood?
□ Yes  □ No  □ Uncertain
<table>
<thead>
<tr>
<th>Behavior</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>In Past</th>
<th>Not Applicable</th>
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<td>Anger/Outbursts of Anger</td>
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<td>Anxiety/Over Sensitivity</td>
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<td>Argues with Adults/Authorities/Teachers</td>
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<td>Argues with Friends/Peers/Siblings</td>
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<td>Avoids/Dislikes Being Touched</td>
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<td>Bed Soiling/Bed Wetting (After Age 5)</td>
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<td>Biting Others</td>
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<td>Biting Fingernails</td>
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<td>Breaking/Disregarding Curfew</td>
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<td>Chewing/Sucking/Pulling/Twirling on Hair</td>
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<td>Constant Activity/Motion</td>
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<td>Constant Chatter/Talking</td>
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<td>Criminal Behavior/Juvenile Delinquency</td>
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<td>Cruelty Toward Animals/Living Things</td>
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<td>Deep Sadness/Depression</td>
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<td>Destruction of Property</td>
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<td>Difficulty Completing Tasks</td>
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<td>Difficulty Concentrating/Focusing</td>
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<td>Difficulty Following Directions</td>
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<td>Difficulty Keeping/Making Friends</td>
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<td>Dishonest/Doesn’t Tell the Truth</td>
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<td>Easily Distracted</td>
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<td>Easily Frustrated/Irritated</td>
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<td>Engaging in Fantasies</td>
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<td>Engaging in Repetitive Behaviors</td>
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<td>Explosive Rage</td>
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<td>Extreme Distress</td>
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<td>Extreme Shyness</td>
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<td>Failed School Year</td>
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<td>Headache/Nausea/Stomach Aches</td>
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<td>Inability to Sit Still/Restless</td>
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<td>Isolates/Withdrawn from Others</td>
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<td>Fire Setting</td>
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<td>Lost in Day Dreams/Thoughts</td>
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<td>Nightmares/Night Terrors</td>
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<td>Problems with Mathematics</td>
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<td>Problems with Motor-Coordination</td>
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<td>Problems Reading/ Writing</td>
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<td>Problems with Speech</td>
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<td>Refusal to Follow Directions</td>
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<td>Refusal to Speak (Mute)</td>
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<td>Self Harm (Cutting Oneself, etc.)</td>
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<td>Sleep Problems</td>
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<tr>
<td>Stares into Space/Vacant Look</td>
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<td>Stealing/Theft</td>
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<td>Suicide Thoughts</td>
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<td>Temper Tantrums</td>
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<td>Threatening Adults/Authorities/Teachers</td>
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<td>Threatening Friends/Peers/Siblings</td>
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<td>Unhappiness</td>
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<td>Verbally Abusive</td>
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<td>Violent with Others</td>
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<td>Running Away</td>
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DEMOGRAPHIC INFORMATION

Client Name: ____________________________  Date: ____________________________

Parent/Legal Guardian Name: ____________________________

Address: __________________________________________

Email Address: ______________________________________

Cell #: ____________________________  Other#: ____________________________

Date of Birth: ____________________________  Social Security #: ____________________________

Race: ____________________________  Marital Status: ____________________________

School: ____________________________  Grade: ____________________________

Primary Care Physician: ____________________________

Address: __________________________________________

Phone #: ____________________________  Fax #: ____________________________

Previous Mental Health Providers: __________________________________________

Referral Source: ____________________________

EMERGENCY CONTACT

In the event of identified potential risk, Key Point Health Services staff members will make every effort to ensure that clients are transported to the closest emergency room for evaluation to determine if a more intensive level of services is appropriate. Please list an emergency contact below.

Name: ____________________________

Relationship to Client: ____________________________

Address: __________________________________________

Cell #: ____________________________  Other #: ____________________________
OPTUM DATA CAPTURE

Client Name ____________________________  Today's Date ________________

What do you prefer to be called? ___________________________________________

Please list any previous names (ex. Maiden name) ____________________________

Mailing Address ___________________________________________________________

County of Residence _______________________________________________________

Living Situation ___________________________________________________________

Maryland Residency ______ Yes ______ No

U.S. Citizenship ______ Yes ______ No

Does the consumer have a legal guardian? ______ Yes ______ No

Parent/Guardian/Social Services/Juvenile Services Contact Information:

Guardian First Name ____________________________

Guardian Last Name ____________________________

Guardian Address _______________________________________________________

Guardian City/State/ZipCode ______________________________________________

Guardian Phone Number ________________________________

Member Additional Details:

Ethnicity - is the individual Hispanic, Latino or Spanish origin? ______ Yes ______ No

Race __ White __ American Indian/Alaskan Native __ Black/African American __ Asian __ Native Hawaiian/Other Pacific Islander

"Primary Language" How well do you speak English? 

____Very Well ___ Well ___ Not Well ___ Not at all

Does the Individual need assistance with communicating in English? __Yes __ No

Do you speak a language other than English at home? (5 years old or older)

____ Yes _____ No ____ Not Available  If yes, which language? ______________________

Employment Status:

____ Full-Time  __ Part-Time  __ Retired  __ Disabled  __ Homemaker

____ Student  __ Institutional/Incarcerated __ Volunteer

____ Other unemployed/Not Seeking Work  ____ Other unemployed/Seeking Work
Primary Source of Income:
____ Wages/Salary  ____ Public Assistance/TCA  ____ Self Employment
____ Retirement/Pension  ____ Unemployment Compensation  ____ Disability
____ Other  ____ Unknown

Type of Insurance:
____ No Healthcare Coverage  ____ Medicaid (Healthchoice)
____ Medicaid (Other than Healthchoice)  ____ Medicare

Client insurance eligibility status:  ____ Medicaid  ____ Uninsured

Educational Level (Highest level of school completed): _______________________

Current Grade Level: _______________________

Marital Status:  ____ Single  ____ Married  ____ Separated  ____ Divorced
____ Widow/Widower  ____ Not Available

Pregnancy:  ____ Yes  ____ No  ____ Not Available

Arrest Status/History (Number of arrests within the past 30 days: [0-96 Numerical values from 0 through 96]; 97 = Unknown)

"Military/Veteran status – Is this consumer a Veteran?"
____ Yes  ____ No  ____ Not Available

Disability Status:
Are you deaf or do you have serious difficulty hearing?
____ Yes  ____ No

Are you blind or do you have difficulty seeing, even when wearing glasses?
____ Yes  ____ No

Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions? (5 years old or older)
____ Yes  ____ No

Do you have serious difficulty walking or climbing stairs? (5 years old or older)
____ Yes  ____ No

Do you difficulty dressing or bathing? (5 years old or older)
____ Yes  ____ No

Because of a physical, mental or emotional condition, do you have difficulty going errands alone such as visiting a doctor's office or shopping? (15 years old or older)
____ Yes  ____ No

Number of times in Self-help support group in the past 30 days: ______

Reason for Disenrollment/Discharge: (TO BE COMPLETED BY KEY POINT)

________________________________________________________________________
CONSENT FOR TREATMENT

Client Name: _______________________________    DOB: ______________________

I am giving permission to Key Point Health Services, Inc., (KPHS) to provide outpatient mental health services to me/my child. I understand that an assessment will be completed by a licensed clinician to help identify my/my child’s specific needs prior to treatment which may include individual, family and/or group psychotherapy. All clients will work with a therapist who will be responsible for service coordination. Clients may be evaluated by a prescriber for the purpose of providing diagnostic confirmation and medication assessment. If medications are considered, I understand that I will be informed of the purpose of such and of any possible risks involved. In the case of an emergency, I authorize the staff of KPHS to provide any and all necessary emergency medical treatment. I am aware that all services are provided under clinical supervision.

My signature below indicates that I have been familiarized with the premises; given information about services provided and that I have received a copy of and understand the following policies and procedures:

- Client Rights & Responsibilities & Grievance Procedure
- Crisis Intervention Services
- Health and Safety Policy
- Maryland Advance Directive
- Notice of Privacy Practices
- Procedures for Discharge & Civility Policy

The following section is only to be completed if a Parent or Legal Guardian is providing consent for treatment in lieu of the above individual.

- I am legally authorized to consent for treatment as the client’s (check one):
  - [ ] Parent(s)
  - [ ] Legal Guardian(s)

- I have provided photo identification and one of the following supporting legal documents (check one):
  - [ ] Birth Certificate
  - [ ] Court Order
  - [ ] Consent for Health Care Affidavit
  - [ ] Other: ____________________________

_____________________________    ______________________
Client/Parent/Legal Guardian Name (Print)    Date

_____________________________    ______________________
Client/Parent/Legal Guardian Signature    Date
HEALTH SERVICES INC.  
OUTPATIENT MENTAL HEALTH PROGRAMS  
RESIDENTIAL CARE AND PSYCHIATRIC REHABILITATION

FINANCIAL INFORMATION

Client Name: ___________________________  DOB: ___________________________

Primary Insurance
Type of Insurance:  □ Medical Assistance  □ Medicare  □ Tricare  □ Uninsured Span
□ Other ___________________________

Policy Holder Name: ___________________________  Member ID: ___________________________

Secondary Insurance
Type of Insurance:  □ Medical Assistance  □ Medicare  □ Tricare  □ Uninsured Span
□ Other ___________________________

Policy Holder Name: ___________________________  Member ID: ___________________________

- I certify that the information given above is correct to the best of my knowledge.
- I understand that in some cases Key Point Health Services, Inc. (KPHS) may not be aware of fees until after my insurance company has been billed and KPHS receives payment.
- I understand that any insurance issues I may have are between me and my insurance company.
- I understand that if I acquire Medicare insurance at any time and fail to provide KPHS with my Medicare information as soon as possible I will be responsible for all fees not paid by Medicare during this time.
- I understand that the state of Maryland requires all individuals 65 years of age and older to apply for Medicare benefits.
- I hereby authorize payment directly to KPHS of the insurance benefits otherwise payable to me but not to exceed the charges for the services rendered.
- I understand that payment is due at the time of service unless prior arrangements have been made and that failure to remit payment may result in discontinuation of services.
- It is my responsibility to notify KPHS of any changes to my insurance.
- I understand that KPHS may bill my insurance company as a courtesy to me however if the insurance company denies claims or changes my co-pay amount, I am responsible for all fees not otherwise reimbursed.
- I understand that KPHS may contact my insurance company and/or employers for verification of eligibility and benefits and information regarding diagnosis and anticipated services may be provided for the purpose of reimbursement.
- I understand that I am required to provide financial information for a carrier to cover services provided to me and if I have not provided the appropriate information as of this date KPHS may charge me the normal and customary fee as determined at the time services are provided.

__________________________________________________________________________  
Client/Parent/Guardian Signature  Date

__________________________________________________________________________  
Witness (KPHS Staff) Signature  Date
CIVILITY POLICY

In order to promote a safe and respectful environment at Key Point, this clinic has instituted a Civility Policy. If a client, client’s guardian, or client’s guest exhibits behavior found to be offensive to any staff person, clients, or visitors the following measures will be utilized:

- The individual will receive a verbal warning from Key Point personnel.
- Should the behavior continue, the individual will be asked to leave the premises.
- If the individual refuses to leave, the police may be called.
- Rude and/or hostile behavior by clients or their parent(s)/guardian(s) will not be tolerated and may lead to discharge.

Behavior considered offensive is defined as including, but not limited to, verbal abuse, physically/verbally threatening others, refusal to wait patiently for the prescriber or therapist, showing disrespect to others i.e. cutting in line, speaking over someone, loud/obscene speech in waiting room or provider offices, creating confrontation or commotion unnecessarily. If you are unsatisfied with the service you receive, please request to speak to a supervisor. If you are still not satisfied, a grievance may be filed in writing with the Clinic Director.

PROCEDURES FOR DISCHARGE

Termination of services shall, whenever possible, be a collaborative process between the client and therapist. A written discharge plan including referrals and conditions for readmission will be provided to clients. Key Point will provide clients with 30 days notice of discharge to help facilitate transition. The following are potential reasons for discharge:

- Missing more than one appointment with a prescriber
- Failure to adhere to treatment recommendations or attendance contracts

Clients will not receive 30 day notice and services will be terminated immediately for any of the following reasons:

- Failure to attend a psychosocial assessment or psychiatric evaluation
- Threatening behavior or harassment including, but not limited to, verbal, sexual, or physical actions, intimidating behavior, excessive phone calls, cyber stalking, gift giving, or suggestive comments
- Boundary violations including, but not limited to, stalking, inappropriate contact.
- Misuse of medications or prescriptions including, but not limited to, violation of any federal or state law.

____________________________________________________________________________________
Client/Parent/Legal Guardian Name (Print)  \__________________________  Date

____________________________________________________________________________________
Client/Parent/Legal Guardian Signature  \__________________________  Date
NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you can obtain access to this information. Please read this notice carefully. Key Point Health Services, Inc. (KPHS) may use and disclose your Protected Health Information (PHI) in accordance with applicable law as of May 2016. KPHS is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. KPHS reserves the right to change the terms of the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. KPHS may disclose your PHI after you have given consent by completing a written authorization. You may revoke an authorization for disclosure of your PHI at any time, except to the extent that we have already made a disclosure based upon your authorization.

PHI may include, but is not limited to, the following:

- Demographic information including names, addresses, birth date, social security number, and phone/fax numbers
- Medical record information including account/record numbers and health insurance beneficiary numbers
- Full face photographic images and any comparable images
- Medical Records

Applicable law and ethical standards may permit the disclosure of information about you without your authorization regarding the following:

- Suspected Abuse or Neglect
- Judicial and Administrative Proceedings
- Deceased Clients
- Medical Emergencies
- Health Oversight
- Law Enforcement and Community Forensic Aftercare Program
- Specialized Government Functions
- Public Health and Safety
- Treatment Coordination between Key Point programs

You have the following rights regarding your PHI:

- To inspect and copy PHI that is maintained in a “designated record set.” Your right to inspect and copy PHI may be restricted in situations where there is compelling evidence that access would cause serious harm to you. KPHS may charge a reasonable, cost-based fee for copies.
- To request that KPHS amend your PHI.
• To request an accounting of disclosures that are made of your PHI. KPHS may charge you a reasonable fee.
• To request a restriction on the use or disclosure of your PHI.
• To request that KPHS communicate with you about health matters in a certain way or at a certain location.
• If there is a breach of unsecured PHI concerning you, KPHS may be required to notify you of this breach, including what happened and what you can do to protect yourself.
• You have the right to a copy of this notice.

• To file a complaint, if you believe your privacy rights have been violated, in writing including your name and contact information to info@keypoint.org, Key Point Health Services, Attention: Chief of Operations, 135 N. Parke Street, Aberdeen, MD 21001, or The Secretary of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201.

Client/Parent/Guardian Signature

Date

Witness (KPHS Staff) Signature

Date