Physician Name _____
Address _____
_____
Phone # ( ) _____ - _____
Fax # ( ) _____ - _____

CHILD AND ADOLESCENT INTAKE QUESTIONNAIRE - PARENT FORM

CHILD'S NAME _____ Date_____
First Middle Last

Birthdate _____ Current Age _____
Month Day Year Years / Months

Address _____

Phone Numbers _____ _____ _____
Home Mother's Cell Father's Cell

CURRENT SCHOOL _____

_____
Address

_____
Phone Number

_____ _____
Main Teacher Principal

Grade _____ Type of Class (Regular, EH, ED, Resource, GATE, etc.) _____

Placement Status (SST, 504, IEP, AB 3632, Etc.) _____

****

FAMILY INFORMATION

FATHER _____ _____ _____
Name Age Highest Degree Attained in School
Biological (⊙) Adoptive (○) Step (○) Foster (○)

_____
Current Occupation

_____
Address and Phone Number, if different from child's

MOTHER _____ _____ _____
Name Age Highest Degree Attained in School
Biological (○) Adoptive (○) Step (○) Foster (⊙)

_____
Current Occupation

_____
Address and Phone Number, if different from child's

OTHER CHILDREN IN THE HOME	AGE	GRADE

OTHERS LIVING IN THE HOME	AGE	RELATIONSHIP TO YOUR CHILD

PARENTS' MARITAL STATUS

Current: Date of Marriage _____ Separation _____ Divorce _____
Prior: Mother married to _____ Date Separated _____ Date divorced _____
Father married to _____ Date Separated _____ Date divorced _____

OTHER TREATING CLINICIANS

REFERRED BY _____
Name Phone Number
_____
Address

THERAPIST _____
Name Phone Number
_____
Address

PRIMARY CARE _____
Name Phone Number
_____
Address

OTHER _____
Name Phone Number
_____
Address

LIST ALL CURRENT MEDICATIONS, VITAMINS, ADDITIVES AND HERBAL SUPPLEMENTS

NAME	DOSE	REASON OR PURPOSE	RESULT/EFFECT

REASON FOR BEING HERE AT THIS TIME

CURRENT PROBLEMS: What brings you here? Please briefly describe your child's current problems starting with the most serious.

****

ONSET: How long ago did the problems begin? How old was your child? Was there a precipitant? Were there any major stresses happening in the family at the time the problems began?

****

TREATMENT: What kinds of interventions have been tried? Have you tried medications, seen other therapists, used any "non-traditional" treatments?

****

FAMILY RELATIONSHIPS: Describe what effects the problems have had on family relationships and family functioning. How does your child get along with each parent and with each brother and/or sister.

****

SCHOOL: Describe your child's function at school. Are there any problems? What are his/her school-related likes and dislikes?

****

PEER RELATIONSHIPS: Describe how your child gets along with other children. Who are his/her best friends? Have his/her problems affected these relationships?

****

PAST PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OTHER PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS AT ANY OTHER TIME? Please describe other mental health problems and what interventions have been made. What have been the results of these interventions?

****

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S MENTAL HEALTH?

****

CHILD'S MEDICAL HISTORY

PAST AND PRESENT MEDICAL HISTORY:

Has your child ever been hospitalized? When and why?

Has your child *ever* had any serious medical illnesses? Please describe all illnesses and their treatments.

Does your child *currently* have any serious medical illnesses? Please describe all current illnesses and their treatments.

Has your child ever had any serious injuries? Please include *all* head injuries. Describe all injuries and their treatments. Did any require hospitalization?

Has your child ever had surgery? Please describe the surgery. Include the date and outcome.

Does your child have any allergies? Please include all medication allergies or food allergies. Has your child ever had any life threatening allergic reactions?

Does your child have asthma? Has it ever required visits to the emergency room or hospitalization? Please describe the seriousness of the asthma and its past and current treatments.

Does your child currently take, or has he/she ever taken, any medication for psychiatric or behavior problems? List all medications used for these problems. Include both past and present medication use.

NAME	DOSE	REASON OR PURPOSE	RESULT/EFFECT

Has your child ever tried, or does your child currently use, any chemical substances? Please list alcohol, tobacco, illegal substances, over-the-counter medications and prescription medications.

Has your child ever been in trouble at home, at school or with the law because of substance use? Please explain.

	YES	NO	NOT SURE
HEARING			
Did your child have recurrent or chronic ear infections?			
Did he/she require surgery and/or tube placement?			
Has your child ever had a hearing problem?			
Has anyone ever questioned your child's ability to hear?			
VISION			
Has your child ever had eye or vision problems?			
Has your child been treated for strabismus or "lazy eye"?			
Has your child ever had any type of eye or vision therapy?			
Does your child wear prescription glasses or contacts?			
NEUROLOGICAL PROBLEMS Has your child had:			
Head trauma or been hit in the head			
Severe headaches			
Seizures			
Seizures only with high fevers			
Encephalitis			
Meningitis			
Loss of consciousness or black outs			
Fainting			
Momentary lapses of consciousness			
Trance-like episodes			
Chronic dizziness			
Double vision			
Tremor			
Unexplained poor coordination			
Trouble walking			
Memory problems			
TOXIC OR DANGEROUS CHEMICALS OR MATERIALS Has your child been exposed to:			
Insulation			
Asbestos			
Fumes			
Metals			
Lead			
Mercury			
Chemicals			
Plastics			
Solvents			
Dyes			

Has your child traveled to a foreign country in the last 10 years? YES NO NOT SURE

Where?_____ When?_____

_____ _____

_____ _____

Are immunizations up to date? YES NO NOT SURE

How is your child's general health currently? _____

Does your child now, or has your child had a past history of, any problems with his or her:

	NOW	IN THE PAST	NEVER	PLEASE EXPLAIN
Head				
Eyes				
Ears				
Nose				
Throat				
Respiratory system				
Shortness of breath				
Chest (i.e. pain)				
Heart or blood vessels				
Digestive tract				
Liver (hepatitis, etc)				
Genito-Urinary tract				
Bones				
Muscles				
Hormone system				
Brain or nerves				
Sleep				
Appetite				

Girls: Age at first menstrual period _____

Is menstruation regular? _____

Are there any difficulties related to menstrual periods? Please explain _____

_____

Is your child sexually active? YES NO NOT SURE

Does he/she have a regular girl- or boy-friend? YES NO NOT SURE

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S MEDICAL HISTORY?

****

FAMILY HISTORY

Blood relatives including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc. Include everyone known to you.

FAMILY MEDICAL HISTORY: GENERAL HEALTH

	NAME	GOOD	POOR	DIED	AGE	ILLNESS OR CAUSE OF DEATH
Father						
Mother						
Brothers	1.					
	2.					
	3.					
	4.					
Sisters	1.					
	2.					
	3.					
	4.					

Have any of your child's relatives ever had any of the following:

	YES	NO	RELATIONSHIP TO YOUR CHILD
Migraine or other chronic headaches			
Seizures/Epilepsy			
Stroke			
High or Low Blood Pressure			
Heart Disease			
Heart Attack			
Heart Murmur			
Tuberculosis			
Emphysema			
Lung Disease			
Asthma			
Hay Fever			
Stomach Ulcers			
Gastric Reflux Disease			
Gallstones			
Diabetes			
High Cholesterol			
Liver Disease			
Hepatitis			
Kidney or Renal Disease			
Nephritis			
Thyroid Disease			
Arthritis			
Obesity			
Infectious Disease			
HIV/AIDS			
Glaucoma			
Gout			
Anemia			
Allergies			
Hemophilia or Bleeding Tendencies			
Sudden Unexplained Death			
Alzheimer's Disease			
Dementia			
Cancer			
Genetic Disorder			

DOES ANY FAMILY MEMBER HAVE ANY OTHER MEDICAL ILLNESS OR DISORDER, INCLUDING HEREDITARY DISORDERS, I SHOULD KNOW ABOUT?

FAMILY PSYCHIATRIC ILLNESS: Blood relatives, including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc. Include everyone known to you.

Have any of your child's relatives ever had any of the following:

	YES	NO	RELATIONSHP TO YOUR CHILD
Depression			
Manic Depressive (Bipolar) Disorder			
Post Partum Depression			
Post Partum Psychosis			
Suicide			
Anxiety Disorder			
Panic Disorder			
Separation Anxiety			
Agoraphobia			
Other Phobias			
Obsessive Compulsive Disorder			
Post-Traumatic Stress Disorder			
Other Stress Disorder			
Anorexia			
Bulimia			
Schizophrenia			
Other Psychotic Disorder			
ADHD			
ADD			
Oppositional Defiant Disorder			
Conduct Disorder			
Antisocial Personality Disorder			
Tourette's Disorder			
Other Tic Disorder			
Autism			
Asperger's Disorder			
Other Pervasive Developmental Disorder			
Alcoholism			
Substance Abuse			
Psychiatric Hospitalizations			

Explain any "Yes" answers. Please include the disorder, relationship of the individual to your child, any treatment that person has received, and the results of any treatment.

Has any family member ever taken any psychiatric or mental health medication?

WHO WAS IT?	MEDICATION	PURPOSE	EFFECT OR RESULT

Has any family member ever had ECT (electroconvulsive therapy) or "shock treatment"?

WHO WAS IT?	PURPOSE	EFFECT OR RESULT

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S FAMILY'S PSYCHIATRIC OR MENTAL HEALTH HISTORY?

OTHER FAMILY HISTORY: Blood relatives, including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc. Include everyone known to you.

Has any relative of your child ever had or experienced any of the following:

	YES	NO	RELATIONSHIP TO YOUR CHILD	PLEASE DESCRIBE THE PROBLEM
School Problems				
Learning Disabilities				
Dyslexia				

LEGAL HISTORY: Has any family member ever been arrested or incarcerated? Please explain.

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S FAMILY'S HISTORY OR EXPERIENCES?

****

CHILD'S DEVELOPMENTAL HISTORY

PREGNANCY

1. Did your child's biological mother have any difficulties or complications during her pregnancy with this child?

	YES	NO	NOT SURE
Spotting or light bleeding			
Heavy bleeding requiring bed rest or special treatment			
Excessive nausea or vomiting lasting more than 3 months			
Weight gain over 30 pounds			
Weight gain under 20 pounds			
High blood pressure and/or excessive fluid build up			
Convulsions during pregnancy			
Toxemia			
Pre-eclampsia			
Gestational diabetes			
Threatened miscarriage or early contractions			
Accidents requiring medical care			
Infection (like a kidney infection) requiring medical care			
Illnesses requiring medical care			
Anemia			
Diabetes			
Heart disease			
Kidney disease			
Measles/German measles			
Flu or other virus			
Exposure to X-rays just prior to or during pregnancy			
Was this pregnancy considered "high risk"?			
Maternal age over 40 years			
Maternal age under 20 years			
Was the pregnancy shorter than 38 weeks?			
Was the pregnancy longer than 42 weeks?			

2. Were any medications prescribed during this pregnancy? _____
   Were any medications taken during this pregnancy? _____
   If "yes" which medications and during which trimester?
   _____
   _____
   _____
   _____

3. During pregnancy, did your child's biological mother engage in any of the following?

   Smoking tobacco ○ YES ○ NO ◉ NOT SURE
   If "yes", how much and during which trimester?
   _____

   Drinking alcohol ○ YES ○ NO ○ NOT SURE
   If "yes", what kind of alcohol, how much and during which trimester?
   _____
   _____
   _____

Any drug use (i.e. marijuana, cocaine, ecstacy, etc.) ◯ YES ◯ NO ◉ NOT SURE
If "yes", which drugs and during which trimester?

_____
_____
_____
_____

PREGNANCY-RELATED

1. Was this pregnancy planned? ◯ YES ◯ NO ◉ NOT SURE

2. Was there a preference for a boy or a girl? ◯ YES ◯ NO ◉ NOT SURE
   Boy ☐
   Girl ☐

3. Was this your child's biological mother's first pregnancy? ◯ YES ◯ NO ◉ NOT SURE
   How many prior live births? _____
   How many prior miscarriages? _____
   How many prior terminated pregnancies? _____

BIRTH

1. Were there any complications at the time of delivery?	YES	NO	NOT SURE
Did the water break more than 24 hours before delivery?			
Prolonged labor (longer than 4 hours)			
Was labor induced?			
Was this child born breech (feet or head first)			
Were forceps used?			
Was suction used?			
Was this a planned Caesarian section delivery?			
Was there an emergency Caesarian section?			
Was anesthesia used?			
Were there seizures?			

2. What was this child's birth weight? _____

3. What were the Apgar scores at 1 minute? _____
   at 5 minutes? _____

NEONATAL PERIOD AND INFANCY

1. Neonatal period	YES	NO	NOT SURE
Was oxygen required ?			
Did the baby require an incubator?			
Was this baby in the neonatal ICU?			
Did the baby remain in the hospital after the birth mother went home?			
Did the baby have jaundice?			
Were there any difficulties with breathing?			
Were there blood transfusions?			
Were there seizures?			

2. Infancy: Was there anything unusual, different or difficult about this child during the first 12 months of life?

Was surgery required? (Don't include circumcision or tongue clipping)			
Had to switch formulas 3 times or more			
Had to use non-milk products			
Cried day and night, couldn't be consoled			
Too quiet or "too good"			
Stiffened up when held, or pushed you away			
Floppy or limp when held, or didn't cuddle with you			
Colicky			
Hard to care for			
Other			

DEVELOPMENTAL MILESTONES

1. MOTOR MILESTONES AND DEVELOPMENT
At what month or year of age did your child:

Roll over _____
Sit without support _____
Crawl _____
Stand holding on _____
Walk holding on _____
Walk well _____
Skip _____
Ride a tricycle _____
Ride a bicycle _____

2. SOCIAL MILESTONES AND DEVELOPMENT
At what month or year of age did your child:

Smile in response to another person _____
Tell one person apart from another _____
Become anxious and cry with strangers _____
Become anxious or cry when placed in a strange environment without his mother _____
Play nursery games such as patty cake or bye-bye _____
Play with dolls or stuffed animals _____
Make up and act out stories _____
Play along-side other children without interaction _____
Play together in cooperation with other children _____

3. SELF-HELP MILESTONES AND DEVELOPMENT
At what month or year of age did your child:

Drink from a cup (not a sippy cup) _____
Eat from a spoon _____
Dress without assistance _____
Use toilet for urine _____
Use toilet for stool _____
Stay dry during the daytime _____
Stay dry at night _____

4. SPEECH AND LANGUAGE MILESTONES AND DEVELOPMENT
At what month or year of age did your child:

Make his first sounds _____
Squeal, gurgle and coo _____
Start babbling and running sounds together _____
Say MaMa and DaDa with meaning _____
Say first word with meaning (other than MaMa and DaDa) _____
Say first phrase (e.g. "I want a cookie") _____
Become easily understood by other _____

Did your child ever:	YES	NO	NOT SURE
Make strange sounds or use strange language			
Have any kind of speech impediment			
Require and/or receive speech therapy			
Have discontinuous language development			
Have language development stop or regress			
Often repeat words or phrases he has just learned instead of responding to what was just said or asked			
Use incorrect pronouns to refer to himself (e.g. "he" or "she" instead of "I" or "me")			
Use incorrect pronouns when referring to others			
Seldom or never begin a conversation with someone else (once he could speak)			
Only talk to himself, not others			

5. OTHER

	YES	NO	NOT SURE
Has anyone ever suggested your child might have a developmental delay?			
Has anyone ever suggested your child might be mentally handicapped or retarded?			
Is your child affectionate and cuddly? Will he sit near you or others?			
Will your child look at people, talk to them and interact with them the way you would expect him to?			

Has your child, or does your child, do any of the following;

Body rocking			
Head banging			
Hand flapping			
Toe walking			
Make repetitive nonsense sounds when old enough to speak normally			

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S DEVELOPMENT OR DEVELOPMENTAL HISTORY?

****

YOUR CHILD'S SOCIAL HISTORY

1. Does your child prefer to play alone or with others? ○ ALONE ○ WITH OTHERS ○ NOT SURE

2. Does your child have any good friends? ○ YES ○ NO ○ NOT SURE
If "yes":

   a. Who are his/her closest friends?

   b. What attracted your child to these friends?

   c. What do they do together?

   d. How often do they get together?

3. What are your child's hobbies?

4. a. What is your child best at doing?

b. What is he/she least good at?

5. Does your child ever feel guilt or remorse for wrong doings? If "yes" how does he/she show it?

6. Does your child feel guilty even when what he/she has done isn't that terrible?

7. a. How well does your child seem to like him/herself?

b. What does he/she like best about him/herself?

8. Does your child make negative statements about him/herself? What are they?

9. Does your child feel like a "loser"?

10. Does your child get picked on or teased? If "yes",
    a. What about or why?

    b. How does he/she handle it?

11. How does your child handle peer pressure?

12. Who is your child most likely to confide in?

13. Which parent is your child closest to?

14. How does your child get along with Mom?

15. How does your child get along with Dad?

16. How does your child get along with siblings?

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S SOCIAL HISTORY?

****

SCHOOL HISTORY

WHICH SCHOOLS HAS YOUR CHILD ATTENDED?

Name of School	Grades Attended	Dates	Reason for Leaving	Type of Class

1. Describe your child's attitude toward school.

2. Describe your child's behavior in school.

3. Has your child ever refused to go to school? If "yes", please explain.

4. a. Which are his/her best subjects?

   b. Which are his/her favorite subjects?

5. a. Which are his/her worst subjects?

   b. Which are his/her least favorite subjects?

6. Have your child's grades changed over time? If "yes", please explain.

7. Has your child been tested for Learning Disabilities? If "yes", please describe the results.

8. Has your child had intellectual testing done? Please describe the results.

9. Has your child been held back or skipped a grade? Please explain.

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD'S SCHOOL HISTORY?

****

FAMILY SOCIAL HISTORY

1. Have there been any recent stresses in the family? Please explain.

2. Has anyone recently left the family or died? Please explain.

4. Has anyone recently joined the family? Please explain.

5. Have there been any recent employment changes or job losses? Please explain.

6. Have there been any recent financial changes (good or bad)? Please explain.

7. How many times has your family moved during your child's lifetime? Please explain your moves and reasons for moving. How did your child adapt to moving?

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR FAMILY?

****

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR CHILD?

****

All Island Behavioral Health - Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by:

☐ **Filomena Buncke PhD, NP, BC.** ☐ **Jill Bruning Hindes, MS PMHNP-BC**

☐ **Kimberly Buncke, PMHNP-BC** ☐ **Kathleen A Bowen, PMHNP-BC**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I am aware that the practice of psychotherapy/psychopharmacology is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are no required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Printed Name

_____

Relationship to Patient (if applicable)

_____ _____

Witness Signature Date

MEDICATION AND CONTROLLED SUBSTANCES AGREEMENT WITH ALL ISLAND BEHAVIORAL HEALTH

I will take my medication(s) at the dose and frequency prescribed. I will not add or decrease the dose of my prescription(s) without discussing this first with my provider r.

I will comply with scheduled appointments. If I know in advance that I am unable to keep a scheduled appointment, I will arrange to reschedule in advance.

I understand there is a fee for a missed appointment.

Should I miss a medication management appointment, my provider may decide not to refill my prescription(s) until I can be seen. In some cases, this could mean being without medication until the next visit.

My provider will be the only person prescribing psychotropic medication for me. I agree not to ask for psychotropic medication from another provider without my provider's knowledge.

I will not request controlled substances from another provider that are prescribed to me by my provider.

I am aware that non-prescribed drugs such as illegal drugs, marijuana, or alcohol are not recommended to be used with psychiatric medications.

I will inform my provider if I am prescribed a pain medication or other controlled substance by another physician.

I will consent to random drug testing.

Positive tests for illegal substances or misuse of controlled substances (benzodiazepines, opiates, etc.) will result in immediate discharge from the practice and a referral to a more appropriate program or level of care.

Prescriptions will not be filled early if they are lost, stolen, or destroyed. I agree to protect my medication(s).

This agreement will be placed in my medical record.

I have read and understand the above guidelines.

For women of child bearing age, it may not be safe to take the prescribed medication if you become pregnant. If at any time you are considering pregnancy, or become pregnant, please inform Jill Bruning Hindes, NPP immediately.

It is understandable that emergencies can occur, and in such occurrences, exceptions to the above guidelines may be made on an individual basis.

_____	_____	_____	_____
Signature of Patient	Date Signed	Signature of Provider	Date Signed

PATIENT: _____ DATE: _____

LABORATORY & PATHOLOGY SERVICES CONSENT FORM

Please be sure to use an in-network lab or pathologist because using an out-of-network lab or pathologist will result in higher out-of-pocket costs.

You are being asked to sign this consent form because the provider requires lab results for one of the reasons reflected below. The provider will indicate the reason at the time of the visit by placing a check mark next to the reason.

☐ One-time testing

☐ Ongoing monitoring (standard order or custom profile testing; valid for one year from signature date below)

If you are not certain which labs and pathologists are in-network, please call your insurance carrier or visit your insurance carrier's website.

Your insurance carrier requires that you select one of the following choices below by placing a check mark next to the choice:

☐ I will use an **in-network** lab or pathologist

☐ I will use an **out-of-network** lab or pathologist. I am aware that I will be responsible for a higher cost share or the entire cost of the lab or pathology services if I use an out-of-network lab or pathologist. I understand that out-of-network labs and pathologists are usually prohibited from waiving member cost share amounts.

Please sign below where indicated.

_____ _____

PATIENT'S SIGNATURE DATE SIGNED

_____ _____

PROVIDER'S SIGNATURE DATE SIGNED

SR:08/08/16

All Island Behavioral Health

Statements of Member's Rights

Members have the right to be treated with dignity and respect.

Members have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability or source of payment.

Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be release without member permission.

Members have the right to easily access timely care in a timely fashion.

Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.

Members have the right to share in developing their plan of care.

Members have the right to have a clear explanation of their condition and treatment options.

Members have the right to information about their insurance company, its practitioners, services and role in the treatment process.

Members have the right to information about clinical guidelines used in providing and managing their care.

Members have the right to ask their provider about their work history and training.

Members have the right to give input on the Member's Rights and Responsibilities policy.

Members have the right to know about advocacy and community groups and prevention services.

Members have a right to freely file a complaint or appeal and to learn how to do so.

Members have the right to know of their rights and responsibilities in the treatment process.

Members have the right to receive services that will not jeopardize their employment.

Members have the right to list certain preferences in a provider.

Statement of Member's Responsibilities

Members have the responsibility to treat those giving them care with dignity and respect.

Members have the responsibility to give providers information they need. This is so providers can deliver the best possible case.

Members have the responsibilities to ask questions about their care. This is to help them understand their care.

Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.

Members have the responsibility to follow the agreed upon medication plan.

Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.

Members have the responsibility to keep their appointments. Members should call the providers as soon as they know they need to cancel visits.

Members have the responsibility to let their providers know when the treatment plan isn't working for them.

Members have the responsibility to let their provider know about any problems with paying fees.

Members have the responsibility to report abuse and fraud.

Members have the responsibility to openly report concerns about the quality of care they receive.

Patient Name: _____

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature Date:

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Clinician Signature Date:

Revised 10/29/2019