MENTAL HEALTH PACKET

Welcome to Wasatch Pediatrics Mental Health! Please complete the checklist below so that we can help you and your child get scheduled in a timely manner. **PLEASE COMPLETE THE MENTAL HEALTH PACKET COMPLETELY!** It is important that our providers have all the necessary information in order to provide the best care for your child. Once the packet is complete and our office has received the documentation, a member of our staff will contact you for an appointment.
****THE PACKET MUST BE COMPLETED BEFORE SCHEDULING FOR MENTAL HEALTH CARE****

Please Complete the Following Checklist:

- ☐ I Have Read Each Page Front and Back
- ☐ I Have Filled out the Questions to the Best of My Knowledge
- ☐ I Have Listed All Medications and Supplements That My Child is Taking
- ☐ I Have Contacted My Insurance to Verify Medication Coverage (Yellow Page)
- ☐ I Have Read and Understand the Requirements for Well Child Exams
- ☐ I Have Reviewed and Understand the Cancellation Policy
- ☐ I Have Read and Understand the Group Therapy Policy
- ☐ Financial Agreement has been reviewed and signed
- ☐ All Parental Signatures are on the Necessary Forms with the Current Date.

You Can Choose one of the Following:

- ☐ I Have Emailed the Mental Health Packet to: draperrecords@wasatchpeds.net
- ☐ I Have Faxed the Mental Health Packet to: (801) 576-5940
- ☐ I Have Delivered the Mental Health Packet to Wasatch Pediatrics in Draper

Parent Guardian Signature: ________________________ **Date:** ________________

Thank you for completing our Mental Health Packet. Someone from our staff will contact you to go over scheduling. If you have any questions or concerns, please feel free to contact us at:

Wasatch Pediatrics – Draper
Phone: (801)-523-3001 Fax: (801)-576-5940

For Office Staff Only: **Document Has Been Scanned In: Yes No (Circle One)**

Staff Signature: ______________________________ **Date Received:** ______________________________

Delivered To: ______________________________ **Date Delivered:** ______________________________

wasatch pediatrics | DRAPER

Patient History and Environmental Assessment

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

GENERAL INFORMATION:

Child's name: ____ Date: ____________________
First *Middle* *Last*

Form completed by: _________________________________ Relationship to child: _______________________________________

(If child is adopted, please state child's age at adoption and date of adoption: ______________________________ (International adoption? Y / N)

Gender of child: ☐ Male ☐ Female Birth date of child: ___________ Age: _______

Usual language of child: __________________ Religion / Spiritual affiliation: ___________________________

Name of child's current school: ____Grade: _______

REFERRAL INFORMATION:

Current Pediatrician or Family Doctor:

Name: ____ Telephone: _______________________

Child's Current Mental Health Professional: (if applicable)

Name: ____ Telephone: _______________________

CURRENT CONCERNS:

What is the main reason for your child's referral to the Wasatch Pediatrics Mental Health Program?

____

____

____

____

How long has your child had these problems? or How long have you been concerned about your child's difficulties?

____

____

Where does your child exhibit these problems? (Check all that apply)

☐ Home ☐ School ☐ Other (specify):____________________________________

PAST MEDICAL HISTORY:

Please check which of the following your child has had and note the age, any complications, and frequency below:

Yes	No		Yes	No	
☐	☐	Hospitalizations	☐	☐	Vision problems (date of last exam:______)
☐	☐	Surgery	☐	☐	Hearing problems (date of last exam:_____)
☐	☐	Trauma (stitches / broken bones)	☐	☐	Asthma/Respiratory Difficulties
☐	☐	Head trauma/Concussion	☐	☐	Endocrine / thyroid problems
☐	☐	Loss of consciousness	☐	☐	Allergies (list: _______________________)
☐	☐	Seizures	☐	☐	Stomach aches
☐	☐	Tics (motor / vocal)	☐	☐	Pica (eating nonfood items)
☐	☐	Staring spells	☐	☐	Diabetes
☐	☐	Tremor	☐	☐	Gastrointestinal difficulties
☐	☐	Poor muscle tone/Falls frequently	☐	☐	Chronic ear infections (PE tubes: Y / N)
☐	☐	Anemia	☐	☐	Elevated lead levels
☐	☐	Headaches (migraines: Y / N)	☐	☐	Cancer
☐	☐	Cardiovascular / heart disease	☐	☐	Other medical problems

Please explain all "Yes" answers from prior Past Medical History Checklist:
____
____
____

SERVICES / INTERVENTION SOUGHT PREVIOUSLY:

☐ Medical Evaluation	☐ Brain Scan (CT / MRI)	☐ Occupational/Physical Therapy	☐ School Modifications
☐ Psychiatric Exam	☐ Laboratory Test (EEG,EKG)	☐ Educational Testing	☐ Neuropsychological Assessment
☐ Medication	☐ Genetic/Chromosome Test	☐ Special Education	☐ Psychological Counseling or Therapy
☐ Neurological Exam	☐ Speech/Language Therapy	☐ Tutoring	☐ Other

What else have you tried to do to help your child with these problems?

____

____

____

MEDICATION HISTORY:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

ALLERGIES:

Does your child have any allergies to drugs? If so, please indicate the reaction.

Medication	**Reaction**

PRE-NATAL HISTORY:

Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment, etc.) in the space below:

Yes	No		Yes	No	
☐	☐	Vaginal bleeding / spotting (When?_____)	☐	☐	Methamphetamines
☐	☐	Toxemia	☐	☐	Alcohol used
☐	☐	Emotional stress	☐	☐	Marijuana used
☐	☐	High blood pressure	☐	☐	Cocaine / crack used
☐	☐	Hospitalization	☐	☐	Other drugs used
☐	☐	Fever	☐	☐	Injuries
☐	☐	Operations (specify below)	☐	☐	Limited prenatal care
☐	☐	Medications used (specify below)	☐	☐	Anemia
☐	☐	Preterm labor	☐	☐	Malnutrition and/or dehydration
☐	☐	Epilepsy (seizure)	☐	☐	Preeclampsia / Eclampsia
☐	☐	Cigarettes used (average #/Day)	☐	☐	Other

Please explain all "Yes" answers:

____

____

____

BIRTH HISTORY:

Was the baby on time? ☐ Yes ☐ No Weight of child at birth: ___________________________

If No, was he/she ☐ Early or ☐ Late and by how many weeks? __________________

Age of mother at birth: ______________________

Age of father at birth: ______________________

Complications during delivery: ☐ Yes ☐ No

Please specify (e.g., emergency c-section; breech birth, etc).____

____

____

CHILD'S POST DELIVERY PERIOD:

Number of days infant stayed in the hospital after delivery:________________________

Please check the following problems that may have occurred after the child's birth and explain the treatment in the space below:

Yes	No		Yes	No	
☐	☐	Trouble breathing / Hypoxia	☐	☐	Infection
☐	☐	Cord around the neck	☐	☐	Fever
☐	☐	Knot in cord	☐	☐	Underdeveloped lungs
☐	☐	Hemorrhage (bleeding) in head	☐	☐	Irregular heart rate
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Sepsis / lumbar puncture
☐	☐	Cyanosis (turned blue)	☐	☐	Congenital anomalies / defects
☐	☐	Need for ventilation	☐	☐	Required resuscitation
☐	☐	Jaundice (Phototherapy: Y / N)	☐	☐	Neonatal intensive care (NICU)
☐	☐	Incubator care	☐	☐	Other (please specify below)

Please explain all "Yes" answers:

____

____

EARLY INFANCY & CHILDHOOD:

Please check the following problems that may have been present to a significant degree during the first few years of life:

Yes	No		Yes	No	
☐	☐	Did not enjoy cuddling	☐	☐	Was not calmed by being held or stroked
☐	☐	Difficult to comfort	☐	☐	Excessive restlessness
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficult feeding / reflux	☐	☐	Sleeping difficulties
☐	☐	Extremely passive	☐	☐	Colic
☐	☐	Poor feeding	☐	☐	Floppy Muscle Tone

Please explain all "Yes" answers:

____

____

DEVELOPMENTAL MILESTONES:

Were you or your pediatrician concerned about your child's development such as talking, walking, and progressing as a child?

☐ Yes ☐ No If yes, make sure to complete below.

Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

Age:

________________Smile in response (social smile)

________________**Walk independently**

________________**Say 1st word other than "mama" or "dada"**

________________You understood 100% of what your child said

Age:

________________Tie shoes

________________Snap, zip, button clothing

________________Toilet trained (urine)

________________Toilet trained (bowel)

FAMILY STRESSORS OR EVENTS:

Have any of the following events occurred within the past 12 months?

☐ Parents divorced or separated ☐ Parent changed job ☐ New baby at home ☐ Child changed schools

☐ Family accident or illness ☐ Death in family ☐ Conflict in family ☐ Child repeated a grade

☐ Family financial problems ☐ Family moved ☐ Family changes ☐ Other: ______________

FAMILY HISTORY:

Has anyone in your family experienced the following: (Biological Relationship to the Child)

Medical Condition	Yes / No	Immediate Family			Father's Relatives	Mother's Relatives
		Dad	Mom	Sibling		
Learning Problems	☐ Yes ☐ No					
Attention-Deficit/Hyperactivity Disorder	☐ Yes ☐ No					
Intellectual Disability	☐ Yes ☐ No					
Autism / Asperger's	☐ Yes ☐ No					
Speech Delay	☐ Yes ☐ No					
Tourette's Syndrome – Tic Disorder	☐ Yes ☐ No					
Neurological Disorders	☐ Yes ☐ No					
Epilepsy/Seizure Disorder	☐ Yes ☐ No					
Bipolar Disorder (Manic Depression)	☐ Yes ☐ No					
Depression	☐ Yes ☐ No					
Panic Attacks	☐ Yes ☐ No					
Anxiety	☐ Yes ☐ No					
Obsessive Compulsive Disorder	☐ Yes ☐ No					
Schizophrenia	☐ Yes ☐ No					
Alcoholism/Substance Abuse	☐ Yes ☐ No					
Genetic Syndromes	☐ Yes ☐ No					
Endocrine/Hormonal Problems	☐ Yes ☐ No					
Hypertension or Cardiac Disease	☐ Yes ☐ No					
Diabetes/Hypoglycemia	☐ Yes ☐ No					
Cancers	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

Have any blood relatives to your child experienced problems similar to those your child is currently experiencing? ☐ Yes ☐ No

If yes, please describe: ____

____

FAMILY STATUS:

Marital Status of Parents:

☐ Married for __________ years ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

▶ **If parents are divorced, who has primary conservatorship of this child (who has the right to consent to psychological services)?**

____

❋A COPY OF THE DIVORCE DECREE IS REQUIRED IN ORDER FOR US TO SEE YOUR CHILD❋

Child currently lives with: *(Please check all that apply)*

☐ Natural Mother ☐ Natural Father ☐ Stepmother ☐ Stepfather

☐ Adoptive Mother ☐ Adoptive Father ☐ Foster Mother ☐ Foster Father

☐ Grandmother ☐ Grandfather ☐ Other (Specify) ___________________________________

Mother's History:

Mother's name: ____ Highest grade completed: _______________

First Middle Last

Occupation: ____

Father's History:

Father's name: ____ Highest grade completed: _______________

First Middle Last

Occupation: ____

FAMILY MEMBERS:

Names of Household Members	Age	Gender M / F	Relationship to Child
__________________________________	_________	__________	___________
__________________________________	_________	__________	___________
__________________________________	_________	__________	___________
__________________________________	_________	__________	___________
__________________________________	_________	__________	___________
__________________________________	_________	__________	___________

SOCIAL:

How many close friends does your child have? _________

Does he/she have a best friend? ☐ Yes ☐ No (If yes, how old is he/she? ____ How long have they been friends? ____)

How easily does your child make friends?

- ☐ Better than average
- ☐ Average
- ☐ Worse than average (explain:____)

How well does your child get along with friends?

- ☐ Better than average
- ☐ Average
- ☐ Worse than average (explain:____)

Does your child get along best with: ☐ Older children ☐ Children of the same age ☐ Younger children

Does your child have problems keeping friends? ☐ Yes ☐ No (if yes, please explain: ____________________________)

Is your child teased/bullied? ☐ Yes ☐ No (if yes, for what: ___________________________________; how often___________)

Does your child tease or bully others? ☐ Yes ☐ No (if yes, how: _______________________________; how often___________)

Is your child physically or verbally aggressive with their peers? ☐ Yes ☐ No (if yes, how often: ___________________________)

EATING HABITS:

How would you rate your child's appetite? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Is your child a picky eater? ☐ Yes ☐ No (if yes, please describe: ____)

SLEEP HABITS:

How many hours total sleep does your child currently sleep at night?________________

Where does your child sleep?

- ☐ Own bedroom
- ☐ Shared bedroom (with whom:____)
- ☐ Room other than a bedroom (describe:____________________________)

Does your child currently experience:

Snoring	☐ Yes	☐ No	
Restlessness	☐ Yes	☐ No	
Difficulty falling asleep	☐ Yes	☐ No	(if yes, how long does it take? _____)
Waking in the night	☐ Yes	☐ No	(if yes, how many times per night? _____ how long to fall back asleep? ______)
Nightmares	☐ Yes	☐ No	(if yes, how often? __________)
Night Terrors	☐ Yes	☐ No	(if yes, how often? __________)
Sleep Walking/Talking	☐ Yes	☐ No	(if yes, how often? __________)

Does your child nap? ☐ Yes ☐ No

EMOTION AND BEHAVIOR:

Please describe briefly any emotional or behavioral problems at *home*:

____

____

Please describe briefly any emotional or behavioral problems at *school*:

____

____

Has your child ever been suspended/expelled from school ? ☐ Yes ☐ No

if yes, how many times? _________ why? ________________________________

Please check any of the following behaviors your child has displayed frequently or intensively within the last 6 months:

☐ Separation anxiety	☐ Anxiety	☐ Low frustration tolerance	☐ Physical aggression
☐ Unhappiness	☐ Unusual fears	☐ Impulsivity	☐ Stealing
☐ Shy / timid	☐ Avoidance	☐ Hyperactivity	☐ Skipping school
☐ Social Isolation	☐ Obsessive-compulsive behaviors	☐ Attention seeking	☐ Quick change of emotions
☐ Lack of confidence / Low self-esteem	☐ Stereotyped / repetitive behaviors	☐ Irritability	☐ Destructiveness
☐ Concern with weight	☐ Poor concentration / Distractibility	☐ Temper tantrums	☐ Cigarette use / Vaping
☐ Sleep problem	☐ Short attention span	☐ Oppositional behavior / noncompliance	☐ Alcohol / substance use
☐ Homicidal thoughts	☐ Suicidal thoughts	☐ Lying	☐ Poor social skills
☐ Other:			

Please provide additional information about any of the above you feel would be helpful: ___________________________________

____

____

____

DISCIPLINE:

Types of discipline you use with your child:

☐ Rewards ☐ Verbal reprimands / verbal demands

☐ Time out (isolation) ☐ Removal of privileges

☐ Ignoring behavior ☐ Physical punishment

☐ Giving in to child ☐ Other (please specify)_________________________________

Which form(s) of discipline has proven most effective? ____

____

EDUCATIONAL HISTORY:

Has your child received DDI (Developmental Disabilities Intervention) services? ☐ Yes ☐ No

if yes, from when to when? ____

Has your child received PPCD (Preschool Program for Children with Disabilities) services? ☐ Yes ☐ No

if yes, from when to when? ____

Were there any adjustment problems in preschool or school? ☐ Yes ☐ No

if yes, please explain: ____

Were you concerned about your child's ability to succeed in preschool or school? ☐ Yes ☐ No

if yes, please explain: ____

Present class placement:
☐ Regular class
☐ Special class (specify: _____________________________________)
☐ Bilingual
☐ English as a Second Language (ESL)
☐ Advanced placement (e.g., ALPS, SALTA, Morningside)

Has IEP testing been completed by school? ☐ Yes ☐ No Date:____

❋ If so, please attach a copy of the school evaluation ❋

How often is your child absent from school? ☐ Often ☐ Seldom ☐ Never Usual reason for absence:__________________

Has your child ever been retained? □ Yes □ No (if yes, what grade? _________ why? _________________________)

Briefly describe you child's current academic difficulties:

____

____

When were these problem first noticed? ____

ACADEMIC PERFORMANCE:

Please list your child's current grades (if applicable):

Math:	__________	Science:		__________
Reading:	__________	Other:	__________	__________
Spelling	__________	Other:	__________	__________
Social Studies:	__________	Other:	__________	__________
Language Arts:	__________	Other:	__________	__________

Does your child have an IEP or 504 plan? □ Yes □ No

Has your child ever been in any of the following educational programs, and if so, how long?

□ Resource Room Services □ Alternative Academics □ Self-Contained Class

□ Life Skills Class □ Behavior/Emotion Disorders Class □ Speech & Language Therapy

□ Occupational Therapy □ Counseling (school based) □ Alternative School Placement

□ Other: ____

PERSONAL:

What are your child's main hobbies and interests?

____

____

What about your child are you most proud of?

____

____

What does your child enjoy doing most?

____

____

What does your child dislike doing most?

____

____

Most Commonly Prescribed Stimulant and Non-Stimulant Medications

****In order to provide your child with the most cost-effective medication, we ask that you contact your insurance company for pricing. Our system will only allow us to see what medications are COVERED WITH YOUR PLAN. **A covered medication could still cost between $100-$200.** We would prefer to select a medication that works well for your child at a price you are comfortable with. Please see the list below for the most commonly prescribed stimulant/non-stimulant medications and provide the cost at your child's appointment.

Stimulant Medications /Generic Names	Generic Cost	Name Brand Cost
Adderall / Dextroamphetamine-Amphetamine		
Adderall XR / Dextroamphetamine- Amphetamine		
Adzenys XR ODT		
Concerta/ Methylphenidate		
Cotempla XR ODT/ Methylphenidate		
Focalin /Dexmethylphenidate		
Focalin XR / Dexmethylphenidate		
Metadate CD		
Metadate ER		
ProCentra / Dextroamphetamine		
Quillivant (Liquid) /Methylphenidate		
Quillivant (QuilliChew) /Methylphenidate		
Ritalin /Methylphenidate		
Vyvanse / Amphetamine		

Non-Stimulant Medications/ Generic Names	Generic Cost	Name Brand Cost
Intuniv / Guanfacine		
Kapvay / Clonidine		
Strattera / Atomoxetine		
Tenex / Guanfacine		

Wasatch Pediatrics Well Child Exams and Mental Health

We will require that your child has had a physical exam with their primary care provider within the last year in order to continue to see our mental health providers.

Please be advised that the mental health care that you receive from our team does not take the place of regular health maintenance visits with your child's pediatrician. If your child has not been seen for a well child visit within the last year, you will have 6 months to complete that visit or you will be unable to schedule any further follow ups with the members of our mental health team.

Additionally, in order to continue care with the mental health team of Wasatch Pediatrics, **your pediatrician must be a pediatrician within Wasatch Pediatrics.** If your pediatrician is currently a physician outside of Wasatch Pediatrics, you will be asked to either choose a pediatrician within Wasatch Pediatrics or be asked to seek mental health care services with another facility outside of Wasatch Pediatrics. We communicate with your Wasatch Pediatrician after every visit to ensure that your child's care is coordinated among all of their providers.

Thank you for your understanding and we look forward to continuing to provide the highest level of care possible.

Sincerely,
Wasatch Pediatrics Mental Health Team

By signing below, I acknowledge that in order to receive services from Wasatch Pediatrics Mental Health program, my child will need to have an annual well visit appointment with their pediatrician at Wasatch Pediatrics.

Patient Name: ____
Signature of Parent/Guardian: ____
Date: ________________________________
Patient Date of Birth: ___________________________

Cancellation and Missed Appointment Fees

Dear Parent/Guardian:

In order for Suzanne Peterson and the mental health team to more fully serve the patients at Wasatch Pediatrics, we are asking for **at least a 24-hour notice of cancellation** prior to your appointment time. For instance, please cancel before 11 o'clock the previous business day if your appointment was at 11 o'clock. By doing so, we will be able to more effectively have patients seen in a timely manner.

In addition, please note that patients that are consistently cancelling or no-showing will be referred to counseling services outside of Wasatch Pediatrics and your future appointments will be cancelled.

In order to gain compliance with this policy, new fees have been attached to missed appointments and appointments cancelled that occur within the 24-hour business period prior to your appointment.

Effective immediately, the missed appointment fees will be as follows:

- **Suzanne Peterson, FNP**
  $50 for consults and follow up appointments

IF YOU ARE 10 OR MORE MINUTES LATE TO YOUR APPOINTMENT, IT WILL BE CANCELLED AND A LATE FEE WILL BE ASSESSED.

*****Please note that cancellation at the time of the reminder calls does not qualify for the 24 hour notice and you will be billed the missed appointment fee.*****

Please know that the institute of this policy is to further increase the availability of the services offered given the length of time needed to appropriately deliver effective mental health care.

Sincerely,

The Staff at Wasatch Pediatrics

By signing below, I acknowledge the change to the Wasatch Pediatrics' Mental Health Program's cancellation policy.

Name: ________________________________ Signature ______________________

wasatch pediatrics | DRAPER

Patient's Name:_________________________________ Date:___________

GROUP WORKSHOP SERVICE AGREEMENT
Updated 12/6/2018

Welcome to Wasatch Pediatrics' Mental Health Program. This document contains important information about our professional services and business policies. As you read, please initial where designated indicating your review and understanding of each respective section. When you sign this document, it will represent an agreement between us.

WORKSHOP FACILITATOR

The Winter 2019 workshops will be facilitated by our new staff therapist. As of the time of printing this document, a new therapist has not yet been hired. If hiring is not completed by the start of the first Winter workshops, the workshops will either be postponed or cancelled. If the workshops are cancelled for Winter 2019, anyone who has signed up prior to the cancellation will receive full refunds for whatever workshop fee they have already paid. We appreciate your patience as we complete the hiring process.

DESCRIPTION OF GROUP WORKSHOPS ________ (Initials)

Psychoeducational workshops are a unique and evidence-based way to treat a number of mental health concerns. Workshop participants benefit from learning new skills, sharing their experiences, and observing other group members share. It reduces feelings of isolation or alienation, and it lessens the stigma attached to mental health problems.

GROUP WORKSHOP RULES ________ (Initials)

1. We will use group member's first names only. Other information (such as phone numbers of minors) may not be exchanged during the course of the group.
2. We will not allow non-group visitors (such as siblings or friends) in our sessions.
3. We will not permit any kind of recordings of our sessions, even by our members or facilitators.
4. Members will encourage them to adhere to privacy/confidentiality provision by not disclosing outside of the workshop any of the issues presented by other group members, as it may be identifiable.
5. I understand that if I or my child violates rules 1 through 4, we may be asked to discontinue the workshop.
6. I understand that the other group members are not therapists and are not obligated to maintain the same ethics and legal provisions that the therapist must adhere. There are specific exceptions to confidentiality in any therapeutic modality. Mental Health professionals have a legal and ethical responsibility to report information to the appropriate persons with or without your consent in the following instances:
    a. if you are a danger to yourself or others;
    b. if there is a suspicion of child or elder abuse;
    c. or subpoenaed by a court to release medical records.
    d. If, in the professional judgment of the facilitator, any of these exceptions apply, a reasonable effort will be made to discuss them prior to the release of information. I understand that my child cannot be absolutely certain that other group members will always keep what they say in the group confidential, even though every group member has agreed to maintain confidentiality.

MEETINGS _________ (Initials)

The group workshops will be 60-minute sessions held on a set day and time for a set number of weeks.

CANCELING/MISSING A GROUP SESSION _________ **(Initials)**

Please make every effort to attend each group session. Not only will you gain valuable information and experience by attending, but your presence contributes to the overall group dynamic. Part of what makes group workshops so powerful is the connection with others who share your same concerns.

We encourage you to attend all sessions, but we understand that sometimes conflicts can arise. Because all groups are prepaid, no fee will be charged for late cancellation or missing a session. However, no refund will be offered either. If you know you or your child will miss more than one group session, it may be best to postpone signing up for group therapy until it better fits into your schedule.

PROFESSIONAL FEES ________ **(Initials)**

For the Winter 2019 therapy groups with set lengths (e.g., nine weeks), the fee per group session is $30, for a net total that differs by workshop length (e.g., nine-session workshops cost a total of $270). For the open enrollment adolescent depression workshop, the fee per group session in $40 when signing up for one session at a time and $30 when signing up for at least three sessions at a time. This fee must be paid in full at least one week prior to the first group session. If your fee has not been paid by that point, you may be removed from the workshop roll and your spot may be given to someone on the waitlist. For prepaid workshops, no refunds will be offered after the first workshop session.

PROFESSIONAL RECORDS __________ **(Initials)**

The laws and standards of my profession require that we keep treatment records. You are entitled to receive a copy of your child's records, or we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or may be upsetting to untrained readers. In addition, it is sometimes difficult for children, especially adolescents, to open up in therapy if they know their parents/caregiver will access their records. Thus, if you wish to see your records, we recommend that you review a summary in our presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

SIGNATURES

Your signature below indicates that you have read the information in this document, asked any questions that you have, and agree to abide by its terms during our professional relationship.

______________________________	______________________________
Name (in print)	Date
______________________________	______________________________
Signature	Relationship to Child

Account #: _____________

Agreement of Financial Responsibility

Mental/Behavioral Health

This form must be signed prior to services being rendered

Wasatch Pediatrics certifies that this office has an established policy for billing all patients for services not covered by their insurance carrier. In the event that services provided are not covered for any reason, I will assume responsibility for all charges accrued.

Also, due to the nature of testing for Mental/Behavioral health issues we ask that when you are given testing for your child that you take the appropriate steps to have it completed and return to the office for a follow-up appointment.

With all that is needed to perform these tests, we will bill accordingly either you or your insurance company. If testing materials are given and not returned there will be a $50.00 charge to your account that you will be responsible for and not your insurance company.

I understand that it is my responsibility to know my insurance coverage and benefits for mental and behavioral health.

Patient Name: _________________________________

Signature of Parent/Guardian: _____________________

Date: __________________