Dell Children's Medical Center
Austin, TX 78723

Texas Child Study Center- New Patient Intake

Date_____

Patient Information

Name_____ Nickname _____ DOB_____
Age_____ Sex_____ Race/Ethnicity_____
Language(s) spoken at home _____
Person completing form: _____ Relationship to child: _____
Child's address_____
City_____ State_____ ZIP_____
Home phone_____ Other (e.g. Child's mobile)_____
Primary care doctor_____ Phone_____
Referred by_____ Phone_____

Caregiver Information (Custodial)

Name_____DOB_____Last 4 digits of SSN_____Age_____ Sex_____
Relationship to child: _____
Address (different from above) _____
Mobile phone _____Work phone_____ Email_____
Please indicate if we may leave a message on mobile phone: ☐Y ☐N Work phone ☐Y ☐N
Employer_____Position_____

Caregiver Information (Custodial)

Name_____DOB_____Last 4 digits of SSN_____Age_____ Sex_____
Relationship to child: _____
Address (different from above) _____
Mobile phone _____Work phone_____ Email_____
Please indicate if we may leave a message on mobile phone: ☐Y ☐N Work phone ☐Y ☐N
Employer_____Position_____

Caregiver Information (Non-Custodial)

Name_____DOB_____Last 4 digits of SSN_____Age_____ Sex_____
Relationship to child: _____
Address (different from above) _____
Mobile phone _____Work phone_____ Email_____
Please indicate if we may leave a message on mobile phone: ☐Y ☐N Work phone ☐Y ☐N
Employer_____Position_____
Biological parent_____ Adoptive parent_____ Foster parent_____ Step-parent_____ Grandparent_____
Legal guardian_____ Guardian_____ Other_____

I UNDERSTAND THAT THERE IS A $25 FEE FOR LATE CANCELLATIONS (LESS THAN 24 HOURS), OR FOR FAILING TO SHOW FOR AN APPOINTMENT. THREE MISSED OR LATE-CANCELLED APPOINTMENTS WITHIN A CALENDAR YEAR MAY RESULT IN DISMISSAL FROM THE CLINIC.

I UNDERSTAND THAT TCSC REQUIRES AT LEAST 72 HOURS (3 BUSINESS DAYS) NOTICE FOR ANY MEDICATION REFILL.

I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT, EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.

SIGNATURE: _____ DATE: _____

Insurance Information

Insurance company:_____ Policy number:_____
Group number:_____ Policy holder name:_____
Address:_____ City:_____ State:_____ ZIP:_____
Phone: _____ Date of birth:_____ Last 4 digits of SSN:_____
Relationship to patient:_____ Employer name:_____
Employer address:_____ City:_____ State:_____ ZIP:_____
Phone number:_____

Pharmacy Information

Pharmacy name:_____ Full physical address:_____
Phone number:_____ Fax number:_____

Please tell us what type(s) of services you are seeking:

☐ Therapy ☐ Evaluation ☐ Medication monitoring

Briefly, please describe the concerns about your child and/or the reason you are seeking services (e.g, any behavioral, emotional or learning concerns at home and/or school, difficulties with peer relationships, etc):

_____
_____
_____
_____

Family Information

Parent's marital status: ☐ Married ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed
If separated or divorced, how long? _____
Contact with non-custodial parent or custody arrangement if any: _____
Any special circumstances in the family situation? _____
Please list all individuals living in the home:

Name	Age	Relationship	Occupation/School

Any recent moves or changes in the family living at home?

_____
_____

Mental Health History

Testing (such as educational, emotional, speech/language) (please bring copies of any reports)

Date	Type of testing	Where was the testing done? (e,g, school, private psychologist, etc.)

If your child has taken medication for attention, behavioral or emotional problems, please list:

Medication	Dosage (e.g. 20 mg 3x day)	Start	End	Prescribed by	Adverse effects

Psychiatric hospitalization or inpatient drug treatment

Place	Date started	Date stopped	Reason for admission

Outpatient mental health professionals seen

Professional's name/specialty (e.g. psychiatrist, psychologist, social worker, school counselor)	Start date	End date	Type of services received

Has your child or family received services or case management through an agency (e.g. Child Protective Services, Department of Mental Health, etc.)

Agency: _____Service:_____

Agency: _____Service:_____

Do you have concerns that your child is using drugs or alcohol? ☐None

Drug name	When started	How often used

Medical History

Major illness	Date	Hospitalized?	Surgery?

Has your child ever had a head injury with loss of consciousness? If yes, please describe:

_____

Has your child ever had a seizure? If yes, please describe:

_____

If your child takes any other medication or supplements for any reason, please list:

_____

Please list ANY drug or food allergies_____

Family History

Does anyone in the **biological** family have:	No	Yes	Relationship to child
Attention problems/ADHD			
Behavior problems in youth			
Learning disability			
Seizures			
Mental retardation			
Tics/Tourette's syndrome			
Autistic spectrum disorder			
Thyroid problems			
Heart problems before age 50			
Depression			
Bipolar disorder			
Anxiety or panic attacks			
Obsessive-compulsive disorder			
Schizophrenia			
Alcohol problems			
Drug problems			
Trouble with the law			

Any other significant family medical or psychiatric history:

_____
_____
_____

Significant psychiatric, behavioral or medical problems in step-, adoptive, or foster family:

_____
_____
_____

Developmental/Health History

Pregnancy and delivery:

Age of mother at birth: _____Medications taken during pregnancy: _____
Gestational diabetes? ☐Yes ☐No Problems with blood pressure or toxemia? ☐Yes ☐No
Infections (including herpes) _____
Smoking ☐Yes ☐No If yes, how many packs per day _____ Alcohol _____Drugs taken _____
Any problems during labor or delivery_____
Duration of pregnancy: _____weeks Type of labor: _____ Birth weight: _____
Any problems after birth: _____

Infancy/Toddler:

Describe your child as an infant and toddler: _____
Problems with feeding ☐Yes ☐No
Severe colic or excessive crying ☐Yes ☐No
Irritable ☐Yes ☐No
Overactive ☐Yes ☐No
Easily overstimulated ☐Yes ☐No
Withdrawn ☐Yes ☐No
Didn't like to be held ☐Yes ☐No
Difficult to soothe ☐Yes ☐No

Developmental milestones (Indicate the age at which your child achieved the following):

Sit up _____
Crawl _____
Walk without assistance _____
Speak in two-word sentences_____
Toilet trained during the day _____
Dry at night _____

School Information

Name of school: _____ School district: _____ Phone: _____
Main teacher (or teacher who knows your child best):_____Current grade: _____

Placement and services (current or past)	No	Yes	Describe (e.g. when, which subject failed or grade repeated)
Early intervention			
Repeated grade			
Suspended			
Failed or is failing a grade or subject			
Received any special education services			

Please describe any current special education services (e.g. IEP, 504 Plan, resource room support):

_____
_____

Is there any history of physical, sexual or emotional abuse of your child? ☐None

_____
_____

Is there any involvement of police or Child Protective Services with your child? ☐None

_____
_____

Other Information

Please add any other information you feel may help us understand your child:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Consent to Treat and Healthcare Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing and treatment as directed my physician or his/her designee. I understand that The Texas Child Study Center includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care. I understand that this Consent to Treat will be valid for each visit I make to The Texas Child Study Center until revoked by me in writing. If applicable, I agree to participate in group therapy with other patients and understand that will necessarily the sharing of participants' health information during the group session. I agree not to disclose any other patient's health information outside of the group therapy session.

2. Consent to Release Information

I acknowledge that The Texas Child Study Center may release my protected health information as necessary for treatment, payment and healthcare operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS. I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by The Texas Child Study Center. I acknowledge and consent to allow The Texas Child Study Center to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

Does The Texas Child Study Center have the right to periodically update and contact my Primary Care Physician (PCP) to establish continuity of care to better care for myself?

_____Yes _____No

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to The Texas Child Study Center all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit, including the imposition of a hospital-based facility fee, as applicable, for each clinical encounter. I understand and agree that I will be responsible for any deductible, co-pay or balance due that The Texas Child Study Center is unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorney's fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for healthcare benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or contractors any information needed for any federal or

state program-related claims. I request that payment or authorized benefits be made to The Texas Child Study Center on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic services

I understand that I may receive a separate bill if my medical care includes lab, X-ray, or diagnostic services that are not provided by The Texas Child Study Center or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

6. Consent to photograph/Digital imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental exposure of healthcare worker

I understand that Texas law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of privacy practice

I acknowledge receipt of the "Notice of Privacy Practices" from The Texas Child Study Center.

By entering my name below, I am providing a digital signature to agree to the terms of the document, which I have read and had the opportunity to ask questions about. If the patient is a minor (or otherwise unable to consent), I have the authority and am signing this consent on the patient's behalf.

_____	_____
Patient printed name	Patient date of birth
_____	_____
Patient/Responsible party signature	Date
_____	_____
Witness	Date