

Omega Health Services

Child Intake (11 to 17 yrs old)

Welcome to our office. We would like to take this opportunity to say thank you for choosing us for your mental health needs. We look forward to providing you with personalized, comprehensive care.

Our office hours are listed below by location. *These hours may vary during the holidays.* Any change in the schedule will be posted in advance on our door for each individual holiday.

Our office policy requires payment at the time of service. The following page lists our current fees so that you may plan accordingly. We do accept many insurances; however, *we advise you to contact your insurance carrier to verify we are in-network with your specific plan prior to your visit and to verify your 'out-patient mental health' benefits, as they are often different than your general medical benefits. Your insurance company may also require authorization to be initiated by the patient and your visit may not be covered if you have not done this prior to your appointment.*

Again, thank you for choosing our office for your behavioral health needs. Please do not hesitate to contact us with any questions that you may have.

State Street Location

5985 W. State St
Boise, ID 83703

Hours:

Monday through Thursday: 9am to 5pm
Friday: 9am to 3pm

*Walk-In Clinic at State St: Monday and Thursday evening from 5pm to 8pm

Emerald Street Location

7235 W. Emerald St, Ste C
Boise, ID 83704

Hours:

Monday through Thursday: 9am to 5pm
Friday: 9am to 2pm

Caldwell Location

1818 S. 10th Ave, Ste 240
Caldwell, ID 83605

Hours:

Monday through Thursday: 9am to 5pm
Every other Friday: 9am to 12pm

Omega Health Services

Below is a list of our basic fees. These fees may vary based on the time spent and the type of services required. If you have any questions regarding specific fees, please contact our billing department. If billing insurance, your fees will be based on the insurance companies negotiated rates and will never be more than our basic fees. Please know that we exhaust every effort to verify eligibility and network status prior to your appointments, and while our providers contract with many insurance plans and networks, we may not be contracted with yours. It is in your best interest to always verify network status and benefits prior to being seen by any providers. In accordance with the 'No Surprise Billing Act' Omega will give you a 'good faith estimate' at each appointment based on the information we obtain while verifying your benefits.

Initial Visit/Psychiatric Evaluation	\$330.00 to \$550.00
Established Pt Follow-up	\$165.00 to \$465.00
Initial Visit w/Therapist	\$270.00
Individual Therapy w/ Therapist—16-37 mins	\$150.00
Individual Therapy w/Therapist—38-52 mins	\$185.00
Individual Therapy w/Therapist—53 + mins	\$265.00
Family Therapy w/Therapist—with or without pt	\$200.00 to \$210.00
Injection (each)	\$45.00
Urine Drug Screen	\$25.00
EKG/ECG	\$35.00
Blood Draw (Venipuncture)	\$24.50
Court Appearance (prepayment required)	\$300.00/hr
Report or Letter Preparation	\$10.00 to \$30.00
After Hours non-urgent calls	\$10.00/call
Returned Checks	\$25.00/incident
Missed Appts	100% of appt fee
Late Cancelled Appts	50% of appt fee

*Please note, our fees are dictated by allowable rates issued by the insurance companies in our area and vary due to the complexity of the visit, the decision making required, and/or time spent.

Patient Information

First Name	Middle Initial	Last Name	Nickname/AKA	
Date of Birth	Social Security Number	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Preferred Pronouns	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other				
Home Address:	Apt #	City	State	Zip
Home Phone #:	Cell Phone #:	Email:		
Preferred Contact? <input type="checkbox"/> Home <input type="checkbox"/> Cell	Preferred Appt Reminder? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Email			
Name of employer:		Employer Phone:		

Responsible Party (Guarantor) Information

Relationship to Patient: Self (If Self, skip to Insurance Information) Spouse Parent Other

First Name	Middle Initial	Last Name		
Date of Birth	Social Security Number			
Home Address (if different):	Apt #	City	State	Zip
Home Phone #:	Cell Phone #:	Email:		

Insurance Information

**Please note that if you do not have your insurance card, you may be responsible for your bill in full.*

***Primary Insurance Company name and address:** _____

Subscriber Name	Date of Birth:	SSN
Relationship to Patient	Policy #:	Group #:

***Secondary Insurance Company name and address:** _____

Subscriber Name	Date of Birth:	SSN
Relationship to Patient	Policy #:	Group #:

Emergency/Next of Kin Contact Information

Nearest Relative not residing with patient (First and Last Name)

Relationship to Patient	Home Phone #:	Cell Phone #:
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Preferred Pharmacy and Location: _____

How Did You Hear About Our Office:

Self-Referred Internet/Website Insurance Company

Friend/Family Other Provider/Facility: _____
Name and Phone

*I hereby consent to treatment by providers at this office. I hereby authorize this office to release to my insurance company any information concerning illness and treatment necessary to expedite insurance payment. I understand that I am ultimately responsible for all charges, regardless of insurance coverage.

Patient/Parent/Guardian Signature: _____ **DATE:** _____

Office and Financial Policy

Please carefully read and initial each statement.

1. Be aware that Omega strictly adheres to the State of Idaho's regulations concerning controlled substances and will not be able to fill these early for any circumstance. Also, be aware that we regularly check the Board of Pharmacy and will be notified if you seek controlled substances elsewhere. We require only 48-72 hour notice on controlled substance prescriptions. We will also require random Urine Drug Screens for any patients receiving controlled substances. **Any requests made prior to a maximum of 3 days early may be cause for termination of care by our office, regardless of the reason for the early request, without exception.** _____
2. I understand that the staff at Omega adheres to the rules and policies of the company and will try their best to help with any situation. I understand that any abusive or aggressive treatment or language directed at staff or providers may be grounds for termination. _____
3. **I understand that if I 'no show' I will be charged 100% of my scheduled appointment time. I understand that if I 'late cancel' (cancel without 24 hr notice), I will be charged 50% of my scheduled appointment time. I understand that this fee is NOT covered by insurance. I also understand that if my account receives more than three missed appointments that my services may be terminated, and my care referred elsewhere, without exception.** _____
4. **I understand that arriving late for my appointment may be considered a 'late cancelation', and in some cases a 'no show', depending on when you show. Anything over half of the appointment time, your provider may not be able to see you, and there could be a charge for the missed appointment.** _____
5. I understand that if I request a personal copy of my records that **there is a charge for this service.** _____
6. **I understand that co-payments and patient portions are due at the time of service and are dictated by the insurance companies.** Failing to collect this payment is a violation of our agreement with your insurance company. Additionally, any patient balance that reaches 60 days will be assessed a 1.5% interest rate compounded monthly. Also, any patient balances that reach 60 days or over without contact or payment will be automatically transferred to collections and care will be terminated. _____
7. I understand that I am ultimately responsible for my bill, regardless of insurance status. I understand that it is my responsibility to contact my insurance company to verify benefits, provider contracting status, and authorization for treatment guidelines prior to my appointment. **Although our providers do contract with many insurance plans, they may not be contracted with yours.** _____
8. I understand that if I request forms to be filled out without an appointment, there is a fee for this service, and that fee depends on the length of time it takes my provider to complete the forms. I also understand that **I must follow up as directed and keep my account current or Omega will be unable to complete my forms.** _____
9. I understand that calling the after-hours answering service for **non-urgent issues such as routine prescription refills and scheduling questions** may result in a fee being assessed to my account. I also understand that **excessive calling may result in a charge on my account**, and the charge is at the discretion of my provider. _____
10. **I understand that if the patient is a child or adolescent, I am solely responsible for the account regardless of divorce or custody.** It will be my responsibility to seek reimbursement from any other parties involved. _____

I give my consent to the office of Omega Mental Health to fax labs/medication prescriptions to the pharmacy or lab of my choice. I have read, understood, and agree with all the above-listed consents and disclosures. Please know that **regardless of signature/initials on this page that all office policies will still be enforced.**

For: _____
Print Patient Name DOB

Signature of Patient/Parent/Guardian

PLEASE UTILIZE OUR PORTAL FOR:

MANAGING YOUR OWN APPOINTMENTS:

You can schedule, cancel, and verify your own appointment.

MANAGING YOUR MEDICATION AND CARE:

You can request refills, send messages to your provider to clarify directions or ask questions, and access visit summaries.

PLEASE FILL OUT THE FOLLOWING TO ACCESS THE PORTAL:

Do you wish to sign up for our online patient portal? Yes No
*If yes, you will need to give us your e-mail address to receive the invitation. (Circle One)

E-mail: _____

OMEGA MENTAL HEALTH

NOTIFICATION AND AUTHORIZATION OF CHARGE

Please carefully read, initial, and sign.

1. I am aware that, per office policy, any appointments that are cancelled late (without 24-hour notice) will incur a fee of 50% of the allotted scheduled time. I am aware that, per office policy, any appointment deemed a 'no show/no call' will incur a fee of 100% of the allotted scheduled time. I am also aware that if I incur a 'late cancellation' or 'no show' charge on my account that the credit card information listed below will be charged for this fee the day of the scheduled appointment. If there is a discrepancy with the charge made, and it is found to be an error, the amount charged will be refunded. _____
2. I am aware that my account must be current at all times. If my account is not current and is scheduled for collections, and I have failed to return phone calls or respond to billing statements, I authorize the balance to be charged to the card listed below, in order to safeguard my credit. _____

Visa MasterCard Amex Discover (circle one)

Account Number: _____

Expiration Date: _____

Zip Code: _____

Security Code: _____

Signature: _____

Card member/account holder acknowledges terms and conditions and agrees to perform the obligations set forth by this agreement with the issuer.

OMEGA HEALTH SERVICES

Consent for Treatment: Unemancipated Minor

Patient Name: _____

Date of Birth: _____

- Authority.** I am the parent, guardian or other person authorized by Idaho law to consent for health care services for the Minor Patient pursuant to Idaho Code § 32-1015.
- Consent for Treatment.** I voluntarily consent to and authorize Omega and its employed or affiliated physicians, practitioners, and staff (collectively "Providers") to render the following health care services to the Minor Patient:
 - Mental Health Care, including but not limited to, counseling, mental illness or psychiatric diagnosis/treatment.
- In the event the parent/guardian is unable to attend the appointment, I authorize the following people to bring the minor child to their appointment:

Name:	Relationship:	Phone No:
Name:	Relationship:	Phone No:
Name:	Relationship:	Phone No:

- If the minor child is old enough to drive themselves, I consent and authorize Omega to provide services:
 - I authorize treatment
 - I do not authorize treatment

*If requested, the provider can call you with any updates or to discuss any suggested changes.

*This authorization shall remain in effect until revoked in writing by the patient.
Submitting a new form will revoke existing form.*

X

Signature of patient/authorized individual

Date

Today's Date _____

Health History

Patient Name _____ Age _____ Birth date _____

Occupation _____ Last Physical Examination Date _____

=====
Are you allergic to any medications? If yes, please list them.

Have you or any member of your family been diagnosed with any of the following conditions? List affected family member, if applicable.

	<u>Self</u>	<u>Family</u>	<u>Date</u>
Abnormal Electrocardiogram	_____	_____	_____
Cancer-where and what type	_____	_____	_____
Cataracts/Glaucoma	_____	_____	_____
Colon or Bowel Trouble	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy	_____	_____	_____
Heart Murmur as Adult	_____	_____	_____
Heart Attack	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Kidney Stones	_____	_____	_____
Liver disease	_____	_____	_____
Lung disease	_____	_____	_____
Nervous system disorder	_____	_____	_____
Poor Blood Clotting	_____	_____	_____
Skin Condition	_____	_____	_____
Stomach or Duodenal Ulcer	_____	_____	_____
Sexually Transmitted Disease	_____	_____	_____
Thyroid Disorder	_____	_____	_____
<u>MEN</u>			
Prostate Problems	_____	_____	_____
<u>WOMEN</u>			
Menstrual Difficulties	_____	_____	_____
Cystitis	_____	_____	_____
Ovarian Cyst	_____	_____	_____
Other Gynecological Problems	_____	_____	_____
Still Menstruating? Yes/No	_____	NA	_____
Age period started _____	Age period stopped _____	Number of pregnancies _____	
Number of children _____	Number of miscarriages _____		

Is there any chance you may be pregnant?

Hospitalization's and Dates:

CHILD/ADOLESCENT INTAKE QUESTIONNAIRE

Parent please be thorough, but be **brief** with your responses when possible. Please respond to every item for complete accuracy.

Patients Name: _____ DOB: _____ Today's Date: _____

Please **briefly** describe the reason for your child/adolescents visit or their current problem(s):

PAST PSYCHIATRIC HISTORY:

Has the patient previously been involved in mental health services? Yes No

Previous Counseling? Yes No If so, please **briefly** indicate **with whom, from when to when and why?**

Please list what, if any, **psychiatric medications they have taken in the past:** None: _____

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Please list their **current psychiatric medications** (by name and amount taken each day): None: _____

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Have they been **hospitalized for psychiatric** reasons? Yes No

How many times: _____

When (age, grade or date is fine) were they first **psychiatrically hospitalized** and **why?**

When most recently and why?

Have they had any past suicide attempts? Yes No How many times: _____

If yes, **by what method?**

If they have attempted suicide more than once, **how old were they when first attempted, and when last?**

SAFETY ISSUES:

Does your child have access to any of the following?

- _____ Large quantities of medications
_____ Firearms or other weapons: (list which types) _____

Does your child have any other safety issue we should know about? _____

FAMILY HISTORY:

Do any members of your immediate or extended family have psychiatric illness? If so, can you name the diagnoses?

Have there been any completed suicides in your family? If so, who and when?

DEVELOPMENTAL HISTORY:

Were there any complications with pregnancy or delivery? Yes No

If so, briefly explain:

List any developmental problems your child has exhibited:

Any known *Developmental Delays*? Yes No If not, proceed to **Medical History** below.

Motor skills: sitting at 6 months: Yes No Walking by one year? Yes No

If not, when? _____

Verbal skills: problems talking by 1 year: Yes No Speech therapy: Yes No

Social skills: Problems with interactions with others: Yes No

Same age friends: Yes No

MEDICAL HISTORY:

List any surgeries your child has had and when:

List any chronic medical illness your child has had (i.e. asthma, allergies, diabetes, etc...):

List any medications the child is currently taking for medical problems:

Are there any known allergies to medications? Yes No If yes, list below:

PSYCHOSOCIAL HISTORY:

Where was your child born? _____

Who raised the child, biological parents? Yes No If not, briefly explain:

Child of original marriage or parents separated or divorced—if so, when?

With whom does the child currently live?

Childhood: OK? _____ Not OK? _____ If not, briefly state why?

Spirituality/Faith/Religious preference? _____

History of having been physically/emotionally/mentally abused: Yes No

If yes, briefly explain over what age period & by whom:

History of having been sexually abused: Yes No

If yes, briefly explain over what age period & by whom:

KNOWN DRUG & ALCOHOL HISTORY:

Known drug or alcohol use? Yes No

If so, when did this begin? (What grade in school or how old): _____

What substances were used?

Has there been any substance abuse treatment? Yes No

TOBACCO HISTORY:

Never Smoked: _____

Current Smoker: Yes No

If yes, please answer the following:

How often?

_____ Some Days

_____ Every Day

How much?

_____ Less than one pack per day

_____ One pack per day

_____ Two packs per day

_____ More than two packs per day

Former Smoker: Yes No

How long ago did you quit: _____

How often did you smoke?

_____ Some Days

_____ Every Day

How much did you smoke?

_____ Less than one pack per day

_____ One pack per day

_____ Two packs per day

_____ More than two packs per day

LEGAL HISTORY/DETENTION:

Please describe any legal problems:

EDUCATIONAL HISTORY:

Current grade: _____ Ever held back? Yes No

Any Special Education:

Please describe any behavior problems at school:

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Diagnosis: _____

Initial Tx: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ Age: _____ Sex: _____ Date: _____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
		During the past TWO (2) WEEKS , how much (or how often) have you...					
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?					
	2.	Worried about your health or about getting sick?					
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?					
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?					
IV.	5.	Had less fun doing things than you used to?					
	6.	Felt sad or depressed for several hours?					
V. & VI.	7.	Felt more irritated or easily annoyed than usual?					
	8.	Felt angry or lost your temper?					
VII.	9.	Started lots more projects than usual or done more risky things than usual?					
	10.	Slept less than usual but still had a lot of energy?					
VIII.	11.	Felt nervous, anxious, or scared?					
	12.	Not been able to stop worrying?					
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?					
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?					
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?					
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?					
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?					
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?					
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?					
		In the past TWO (2) WEEKS , have you...					
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?		<input type="radio"/> Yes	<input type="radio"/> No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?		<input type="radio"/> Yes	<input type="radio"/> No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?		<input type="radio"/> Yes	<input type="radio"/> No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?		<input type="radio"/> Yes	<input type="radio"/> No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?		<input type="radio"/> Yes	<input type="radio"/> No		
	25.	Have you EVER tried to kill yourself?		<input type="radio"/> Yes	<input type="radio"/> No		

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: _____ Sex: _____ Date: _____

Relationship with the child: _____

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
		During the past TWO (2) WEEKS , how much (or how often) has your child...					
I.	1.	Complained of stomachaches, headaches, or other aches and pains?					
	2.	Said he/she was worried about his/her health or about getting sick?					
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?					
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?					
IV.	5.	Had less fun doing things than he/she used to?					
	6.	Seemed sad or depressed for several hours?					
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?					
	8.	Seemed angry or lost his/her temper?					
VII.	9.	Started lots more projects than usual or did more risky things than usual?					
	10.	Slept less than usual for him/her, but still had lots of energy?					
VIII.	11.	Said he/she felt nervous, anxious, or scared?					
	12.	Not been able to stop worrying?					
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?					
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?					
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?					
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?					
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?					
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?					
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?					
		In the past TWO (2) WEEKS , has your child ...					
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know	
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know	
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know	
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know	
XII.	24.	In the past TWO (2) WEEKS , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?					
	25.	Has he/she EVER tried to kill himself/herself?					

Omega Health Services

Acknowledgment of receipt of Notice of Privacy Practices:

You may refuse to sign this acknowledgment

I have received a copy of this offices Notice of Privacy Practices.

Please ask receptionist for a brochure if needed

Print Name

Signature

Date

<p>For Office Use Only</p>

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign.

Communication barriers prohibited obtaining the acknowledgment.

An emergency situation prevented us from obtaining acknowledgment.

Other: _____