SunDance Behavioral Resources, LLC

Youth Registration & History Form

Patient Name _____ Sex: M / F Date of Birth ___/___/___ Age _____

Address_____

_____
City State Zip

Best phone number for appointment reminder:
_____

Alt Phone: _____

Guardian Name: _____

School: _____

Grade: _____

Employment: _____

Patient's Social Security #: _____

Insured: Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other

Name _____ Sex: M / F Date of Birth ___/___/___ Age _____

Address_____ _____ _____
City State Zip

Insurance Plan: _____ ID# _____

Authorization Number: _____

Copay $_____ Deductible $_____ Limit of Sessions per Year _____

Who referred you to SunDance Behavioral Resources? _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Who is the custodial parent or legal guardian of the patient? _____

Additional Members of Home & Ages _____

Is your child involved with DCFS? If yes, please explain: _____

_____

_____

_____

Is your child court ordered to have mental health or substance abuse treatment? If yes, please explain: _____

_____

_____

Medical History

Please list any medications your child currently takes: _____

_____

Please list any past medications your child has taken:_____

_____

Who is/was the prescriber for these medications? _____

Please list any medication allergies _____

What is the approximate date of your child's last physical exam? _____

Please describe any additional current medical problems: _____

_____

Does your child use any tobacco products, alcohol or drugs? _____

_____

Please list any previous mental health diagnosis: _____

Please list any history of psychiatric hospitalizations or intensive outpatient treatment of your child:_____

_____

_____

Please list any history of self-harm or suicide attempts by your child:_____

_____

Does your child have any developmental delays? If yes, please explain: _____

_____

_____

What is/are the main reason(s) you are seeking mental heath treatment for your child at this time?_____

_____

_____

Please indicate if your child has had any of the following conditions:

☐ Tuberculosis	☐ Thyroid Disorder	☐ Chronic Bronchitis
☐ Diabetes	☐ Pneumonia	☐ Glaucoma
☐ Emphysema	☐ Cancer	☐ Rheumatic Fever
☐ Epilepsy	☐ Venereal Disease	☐ Heart Disease
☐ Asthma	☐ Allergies	☐ Stroke
☐ Jaundice	☐ Anemia	☐ Hepatitis
☐ Liver Disease	☐ Kidney Disorder	☐ Stomach Ulcer
☐ High Blood Pressure	☐ Head Injury	☐ Other:

Has your child recently experienced any of the following symptoms?

☐ Excessive Fatigue	☐ Numbness of Tingling	☐ Swollen/Sore Glands
☐ Chronic Cough	☐ Blood with Cough	☐ Abnormal Chest X-ray
☐ Wheezing	☐ Heart Murmur	☐ Other Heart Problem
☐ Changes in Bowels	☐ Rectal Bleeding	☐ Pain/Difficulty Urinating
☐ Weight Change	☐ Recurrent Stomach Pain	☐ Black Stools
☐ Chest pain	☐ Blood in Urine	☐ Shortness of Breath
☐ Swelling in Limbs	☐ Easy Bleeding/Bruising	☐ Frequent Headaches
☐ Heart Palpitations	☐ Blurred Vision	☐ Dizziness
☐ Sexual Difficulties	☐ Suicidal Thoughts	☐ Balance Problems
☐ Atypical Vaginal Bleeding	☐ Infertility/Impotence	☐ Sexual Pain
☐ Excessive Perspiration	☐ Trembling/Shaking	☐ Flashbacks
☐ Sadness/Crying	☐ Feelings of Guilt	☐ Poor Concentration
☐ Feelings of Unreality	☐ Loss of Interest	☐ Change in Appetite
☐ Sleep Difficulty	☐ Excessive Sleep	☐ Avoiding Situations
☐ Irritability	☐ Obsessions	☐ Compulsiveness
☐ Low Energy	☐ Feelings of Worthlessness	☐ Easily Distracted
☐ Feeling Overwhelmed	☐ Wishing to Run Away	☐ Restlessness

Patient/Guardian Consent to Treatment/Agreements

Please initial beside each section to indicate that you have read and understand each policy:

_____ **Copays and Fees for Non-Insured Clients are due at the time of service.** If client is unable to pay **co pay, a $10.00 billing fee is charged. SunDance is unable to carry a balance in excess of $50.00. Non-compliance in payment arrangements may result in termination of treatment at SunDance.**

___ **Cancellations and Missed Appointments**

Missed appointments cancelled with less than 24 hours notice prior to the appointment must be paid in full by the patient or guardian. The charges for missed appointments with a therapist are $65.00 and for a Provider $50.00 per session. Insurance companies do not pay for these. SunDance strictly adheres to this policy. Missing three unexcused appointments may result in a termination of treatment at SunDance. If you are under the care of a psychiatrist, a transition prescription will be provided.

____ **Prescription Refills**

Insurance companies do not reimburse for prescriptions researched and filled between appointments. You will be charged $15 for any prescriptions refill and only up to your next appointment. Some schedule II prescriptions are required by law to be written every 30 days, and are excluded.

____ **Paperwork and Letters**

SunDance providers will not fill out disability, FMLA, or Insurance paperwork unless you are an existing patient of one year. Letters requested by therapists and doctors outside of an appointment will include a $25.00 charge.

____ **Collections and Legal Fees**

Returned checks are charged at $20 each. Should any of your charges with SunDance become 30 days past due, a **finance charge of 1.5%** will be added each month. Should collection become necessary, **your signature on this document indicates your agreement to pay an additional 40% of the amount overdue** as a collection fee in addition to all legal fees connected to the collection, with or without suit, including attorney fees and court costs.

____ **Binding Arbitration Agreement**

This agreement requires that you submit all future claims to arbitration instead of having the claim heard in court by a judge or jury. This agreement is included to minimize the cost of any disputes that may arise from your contact with SunDance. You may decline to sign the arbitration agreement and still receive health care at SunDance. Simply write "I decline the binding arbitration agreement" above your signature below. You have the right to have all of your questions about arbitration answered.

____Costs of Services Not Covered by Insurance and other 3rd Party Payers.

On occasion there is need for SunDance to provide services that are not covered by insurance or other 3rd Party payers. These may include, but are not limited to letters, reports, conversations or other communication to attorneys, government agencies, school or employment entities etc. This also includes any required response to subpoenas, court orders, etc. SunDance will always make a good faith effort to notify the patient or responsible party and will release records only as required by law. In such an event any costs incurred will be billed to the corresponding patient or responsible party.

Primary Care Physician

In order to offer the best care possible, we would like to notify your primary care physician of your care at SunDance. **This is recommended, but not required.**

Please initial **one**:

_____ I authorize SunDance Behavioral Resources to release important information about my mental and physical treatment to my doctor.

Doctor's Name	Address	Phone Number
_____	_____	_____

_____ I do not authorize notification to my doctor

Your signature below indicates that you were given this Consent to Treatment and agree to its terms including the cancellation policy, prescription charges, collections and legal fees, fees and billing policies, and binding arbitration agreement and that you have received the HIPAA Notice form. It also indicates your agreement to give SunDance all rights to payments from your insurance company or other third party payer.

We encourage you to use our website **www.sundancebehavioral.com** to contact us re: appointments, medication refills, and any communication with our providers

Guardian Signature: _____ Date: _____