SunDance Behavioral Resources, LLC

Youth Registration & History Form

Patient Name _____

Guardian(s) Name(s) _____

Relationship(s) _____

Address_____

_____
City State Zip

_____ _____
Phone# for appointment reminder Whom

_____ _____
Alt Phone # Type

_____ _____
Name Relationship

Patient Information:

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

School: _____

Grade: _____

Employment: _____

Patient's Social Security #: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

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

_____

Additional Members of Home & Ages:_____

_____

_____

Insured: Patient's relationship to insured: _____

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

Address_____ _____ _____
City State Zip

*****If your insurance changes, it is your responsibility to let SunDance know.*****

Insurance Plan: _____

Who referred you to SunDance Behavioral Resources?

_____

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? Y/N. If Y, please list type and frequency:

_____

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?

_____

_____

_____

_____

_____

Additional Information

_____

_____

_____

_____

_____

_____

_____

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

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

Has your child recently experienced any of the following symptoms?

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

Guardian Consent to Treatment/Agreements

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

____ Co-pays and Fees for Non-Insured Clients are due at the time of service.

____ 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 therapy appointments are $75.00, and for a Psychiatrist $75.00 per session**. Insurance companies do not pay for these. SunDance strictly adheres to this policy. Missing three (3) 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.

____ Late Arrival
Please be advised if you are here for a psychiatrist appointment and you are more than 10 minutes late for a 20 minute medication check appointment, most doctors will not be able to see you and there will be a $75.00 charge for a missed appointment.

____ Prescription Refills
Insurance companies do not reimburse for prescriptions researched and filled between appointments. **You will be charged $15 for any prescriptions filled outside of an appointment and only up to your next appointment.** Some schedule II prescriptions are required by law to be written every thirty (30) days, and are excluded.

____ Paperwork and Letters
SunDance providers will not complete Disability, FMLA, or Insurance paperwork unless you are an existing patient of one (1) full year. Letters requested from therapists and/or doctors outside of an appointment will include a $25.00 charge.

____ Collections and Legal Fees
A $20 fee will be incurred for each returned check. 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 have the right to have all of your questions about arbitration answered. 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 on the next page.

____ Costs of Services Not Covered by Insurance and other Third Party Payers.
On occasion there is need for SunDance to provide services that are not covered by insurance or other third 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(s) 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 decline authorization to notify to my child's doctor.

☐ I authorize SunDance Behavioral Resources to release important information about my child's mental and physical treatment to my doctor.

_____
Doctor's Name

_____ _____
Address Phone Number

In order to be seen Guardian must present Photo ID.

By signing below, I acknowledge I have received and understand all parts of this Registration form, including the Consent to Treatment, and that I agree to the terms herein. I also acknowledge I have received the HIPAA Notice form. I give SunDance Behavioral Resources, LLC all rights to payments from my insurance company or other third party payer(s).

Signed this _____day of _____, 20_____

_____
Guardian Name (PLEASE PRINT)

_____
Guardian Signature

We encourage you to use our website www.sundancebehavioral.com to contact us regarding: appointments, medication refills, and any communication with our providers.
Email us at: office@sundancebehavioral.com