



Childs Name: _____

PLEASE READ AND INITIAL EACH STATEMENT

_____ **CONSENT TO TREATMENT:** I consent to mental health (i.e. psychological/ psychiatric) evaluation and/or treatment by staff from Katie’s Way. In doing so, I understand, acknowledge and affirm that such mental health (i.e. psychological/ psychiatric) evaluation and/or treatment services may involve physical evaluation and blood testing.

_____ **ACKNOWLEDGEMENT:** By initialing here, I acknowledge that all information provided, whether verbal, in writing, or through any form of digital communication will be utilized and binding to Katie’s Way, LLC or Katie’s Way Charities, Inc., or collectively. Further, at any point in which Katie’s Way is referenced, whether verbally, in writing, or through any form of digital communication this will have the same meaning as Katie’s Way, LLC or Katie’s Way Charities, Inc., or collectively.

_____ **RECEIPT OF PRIVACY PRACTICES:** We are required by law to provide this notice to you and obtain your acknowledgement of this receipt prior to providing any services to you. I acknowledge receipt of Notice of Privacy Practices.

_____ **EMERGENCY RESCHEDULES:** It will be a top priority for Katie’s Way staff to see you on time for your appointments. However, due to unexpected clinical emergencies, there may be a time that clinical staff at Katie’s Way need to call and delay a clinic appointment or reschedule it for another day.

_____ **LATE ARRIVALS:** We ask that you call and let the front office know if you are running late to your appointment. If you are more than 10 minutes late for a medication appointment, or more than 15 minutes late to a therapy appointment, you will need to reschedule.

_____ **MEDICATION REFILLS:** If you need a refill, please call your pharmacy first. Please allow 72 hours for a prescription to be refilled. If you have not had an appointment within the recent months you may be required to schedule an appointment to be seen before we refill your medication. Requests will not be received by the Katie's Way medical staff on weekends or holidays. Refills may be delayed if you do not schedule and attend regular appointments.

Patient/Guardian Signature

Date



Adolescent Form



Childs Name: _____

SCHEDULING & ATTENDANCE POLICY

How appointments are scheduled:

Your treatment plan will be determined by the individual provider at the initial evaluation and on an ongoing basis. Your provider will recommend the number of treatment visits and visit frequency.

Our scheduling policy is that appointments are typically scheduled out 2-months at a time. After you discuss your treatment plan with your provider at each visit, please stop at the front desk to schedule and confirm upcoming appointments. You can always add additional appointments to the schedule 2-months ahead of time to plan and hopefully get the appointment that work best for your schedule. Please understand that certain times of the day are the most popular for all patients or families. Our providers and scheduling staff attempt to accommodate all our patients' needs to the best of our abilities. However, there may be some situations in which appointments times are only available at certain times of the day.

The importance of appointment attendance:

We realize that appointments may need to be rescheduled from time to time due to conflicts of schedule, family matters, and illnesses.

Not showing for scheduled appointments or cancelling an appointment without sufficient notice is a significant issue for 3 main reasons:

1. Not keeping an appointment (No-shows) or having late cancellations of your scheduled appointments negatively impacts you or your child's treatment. Psychological and psychiatric treatments require ongoing consistency for them to be effective. If you miss scheduled appointments it can delay the treatment plan or make the treatment less effective, making it harder for us to help you or your child the best that we can.
2. No-shows and late cancellations can negatively impact others in the community. If there is a no-show or a late cancellation, it does not allow us to fill that appointment time with other patients that may need to get in or are waiting for a sooner appointment. Further, no-shows and cancellations is one of the biggest challenges Katie's Way faces in being able to provide services to our community.
3. No-shows and late cancellations affect our providers; their time is valuable and when you cancel or no-show for an appointment they now have space in their schedule that was reserved for you personally.

Our Attendance Policy:

If you become aware that you will miss an appointment or need to reschedule, please call the office at 785-320-7331 as soon as you can.

1. We ask that you call and let the front office know if you are running late to your appointment. If you are more than 10 minutes late for a medication appointment, or more than 15 minutes late to a therapy appointment, it is at each provider's discretion on whether you can be seen that day. If you are seen it will only be during the remaining allotted time of your appointment.
2. For cancellations, our policy is that you let us know **by 3:00PM the day prior** to your scheduled appointment that you need to cancel. If your appointment is on a Monday, please make every effort to



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Childs Name: _____

SCHEDULING & ATTENDANCE POLICY CONTINUED

inform us of a cancellation by 3:00PM the Friday prior to your appointment. If this is not possible, please call and leave a voicemail to let us know over the weekend.

3. If you need to cancel an appointment late (after 3:00PM the prior business day) please call and let us know the reason for cancelling. By calling and letting us know, even if it is late, will allow us to try to fill that open spot with a patient on our wait list. Reasons for late cancellations will be reviewed by your provider and the Katie’s Way director so that a reasonable plan for your treatment can be continued.

4. The **first no-show or late cancellation** will result in a reminder of our attendance policy and encouraging you to give us appropriate notice if you cannot keep any upcoming appointments.

5. The **second no-show or late cancellation within a 2-month period** may result in the following:

- * Your future scheduled appointments being cancelled.
- * You may need to schedule 1 visit at a time with your provider rather than scheduling out appointments.
- * If you successfully attend 3 scheduled appointments in a row without no-shows or late cancellations, you would then be allowed to schedule out for 2-months again and resume the regular scheduling policy.

6. If no-shows or late cancellations continue to occur, your appointment attendance will be addressed by your individual provider and the Director of the clinic. Katie’s Way reserves the right to discharge you or your child from our care due to frequent cancellations or no-shows.

Important: Katie’s Way reserves the right to discharge any patient from services/care

By signing below, you acknowledge that you have read and understand the scheduling and attendance policy.

Patient/Child Printed Name

Patient/Parent/Guardian Signature

Date



Adolescent Form



Childs Name: _____

PATIENT INFORMATION

Patient Legal Name _____

First

Middle

Last

Patient Preferred Name _____

Legal Guardian Name _____

Patient Date of Birth _____ Gender _____

Billing Address _____

Street

City

State

Zip Code

Home Phone _____ Work Phone _____

Mobile Phone _____ Email Address _____

INSURANCE INFORMATION

Primary Insurance Provider _____ Effective Date _____

Policy Number _____ Group Number _____

Name of Subscriber _____

First

Middle

Last

Subscriber Date of Birth _____ Relationship to Patient _____

Subscriber Gender _____ Subscriber Social Security No. (Tricare only) _____

Subscriber Address _____

Street

City

State

Zip Code

PHARMACY INFORMATION

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____



Adolescent Form



Childs Name: _____

PATIENT/ LEGAL GUARDIAN INSTRUCTIONS:

Complete and return this form along with the following:

- ✓ A copy of your insurance card(s), if applicable
- ✓ Copies of your child's Individualized Education Program (IEP), if applicable
- ✓ Copies of any 504 plans or other educational testing records, if applicable

Your Child's Name: _____ Child's Date of Birth: ____/____/____

Who referred your adolescent to our clinic? _____

What was the reason for referral? _____

Who is your adolescent's primary care provider? _____

What is your main concern about your adolescent? _____

What are your adolescent's best qualities? _____

What are you hoping Katie's Way can help with the most? _____

How does your adolescent feel about coming? _____

Has your adolescent been seen by other developmental, behavioral or mental health professionals, such as psychologists, psychiatrists, or counselors?

No Yes, list and explain.

<u>Name of Professional</u>	<u>Date(s)</u>	<u>Reason/Diagnosis</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Adolescent Form



Childs Name: _____

FAMILY INFORMATION:

Birth Mother: _____ Age: _____

Occupation: _____

Home Phone: (____)____ - _____ Work Phone: (____)____ - _____ Alternate Phone: (____)____ - _____

Address: _____
Street City State Zip

Birth Father: _____ Age: _____

Occupation: _____

Home Phone: (____)____ - _____ Work Phone: (____)____ - _____ Alternate Phone: (____)____ - _____

Address: _____
Street City State Zip

If child is not living with birth parents, who does the child live with? (Otherwise, leave blank)

Name: _____ Stepmother Adoptive Mother Guardian Foster Mother

Age: _____ Occupation: _____

Home Phone: (____)____ - _____ Work Phone: (____)____ - _____ Alternate Phone: (____)____ - _____

Address: _____
Street City State Zip

Name: _____ Stepfather Adoptive Father Guardian Foster Father

Age: _____ Occupation: _____

Home Phone: (____)____ - _____ Work Phone: (____)____ - _____ Alternate Phone: (____)____ - _____

Address: _____
Street City State Zip

(Siblings) Brothers and Sisters

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Living in the Home?</u>	<u>Health or Learning Problems</u>
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Any mental health history in the immediate or extended family?



Adolescent Form



Childs Name: _____

ADOLESCENT'S CURRENT HEALTH FUNCTIONING:

SLEEP

What is your adolescent's typical bedtime? _____ How about typical wake time? _____

Do they sleep in significantly on non-school days? _____

Do you have any concerns with your adolescent's sleep (quality of sleep, ability to sleep on his/her own, changes in sleep patterns)? _____

DIET/NUTRITION

Do you have any concerns about your adolescent's diet, eating behavior, or recent changes in appetite/weight? _____

PHYSICAL ACTIVITY

Does your adolescent get any physical activity or exercise on a daily basis? If so, what kinds of activities?

MEDICAL AND DEVELOPMENTAL HISTORY:

PREGNANCY AND BIRTH HISTORY

How old was the birth mother when your adolescent was born?: _____ years

Did the birth mother have any health problems during the pregnancy?: _____

Were there any complications during labor and delivery? _____

Did your child have any health problems following birth? _____

MEDICAL HISTORY

Does your adolescent have allergies to any medications? _____

Has your adolescent's vision been checked? No Yes

Does your adolescent wear glasses/contacts? No Yes

Describe any vision problems: _____



Adolescent Form



Childs Name: _____

Has your child's hearing been checked? No Yes

Describe any hearing problems: _____

Serious Illnesses, Injuries, Surgeries, or Hospitalizations (including psychiatric hospitalizations):

Date or Age of Child

Reason (Type of Illness/Injury/Surgery/Hospitalization)

Are you aware of your adolescent using alcohol or any drugs? _____

MEDICATIONS:

Current Medications (List names and what for)				
Name of Medications	1.	2.	3.	4.
Dose/Frequency				
Start Date				
Reason for Use				
Prescriber				

Previous Medications (List names and what for)				
Name of Medications	1.	2.	3.	4.
Dose/Frequency				
Start Date				
Reason for Discontinuing				
Prescriber				

Dietary/Herbal Supplements (List names and what for)				
Name of Medications	1.	2.	3.	4.
Dose/Frequency				



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GROWTH AND DEVELOPMENT

Motor:

At what age did your child do the following? Sit alone: _____ Crawl: _____ Walk alone: _____

Compared to siblings or friends, was your child awkward or slow to develop motor skills, like running, skipping, climbing, biking, playing ball?: _____

Handedness: Right Left Both

Has your child had occupational or physical therapy? _____

Language:

When did your child- Speak first word: _____ Put 2-3 words together: _____

Does your child have any speech delays or problems, like stuttering or being difficult to understand?

Was speech/language therapy ever necessary? _____

Besides English, any other languages are spoken in the home? _____

SOCIAL FUNCTIONING

Do you have any concerns about your adolescent's social functioning or relationships?

Check all that apply to your child.

- Gets along well with other peers
- Gets along with adults
- Has friends
- Has a good sense of humor
- Acts aggressively towards others
- Seems anxious around others
- Problems with peer pressure
- Understands social cues
- Keep friends

Is your child in any social groups, or social experiences? (sports, drama, church, scouts) _____



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BEHAVIOR MANAGEMENT

Do you have concerns about your adolescent's behavior? _____

Who ordinarily disciplines your child? _____

How is your adolescent disciplined?

- Taking Away Privileges
- Sending to Room
- Talking or Reasoning
- Other: _____

Does it work? No Yes

Do adults caring for the adolescent agree on discipline? _____

EDUCATIONAL HISTORY

What school does your adolescent attend? _____

Current Grade? _____

School Address: _____

Street

City

State

Zip

Teacher's name: _____ Counselor's name: _____

Principal's name: _____ District: _____

Type of Placement: Regular Learning Disability Behavior Disorder Resource Room

Any Educational Diagnosis: Learning Disability Behavior Disorder Intellectual Disability

Date of Last Educational Testing (please send copy): ____/____/____

Date of last IEP, if any (please send copy): ____/____/____

Any academic problems at school? _____

Any behavioral problems at school? _____



Adolescent Form



Childs Name: _____

SUMMARY

Anything else you would really like us to know about your adolescent? _____

Signature of Person Completing This Form

Printed Name of Person Completing This Form

Relationship to Child

____/____/_____
Date