Child Form

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

Child 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

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

Child 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 _____

Child 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 child to our clinic? _____

What was the reason for the referral?_____

_____

Who is your child's primary care provider? _____

What is your main concern about your child? _____

What are your child's best qualities? _____

_____

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

_____

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

□ No □ Yes, list and explain.

Name of Professional	Date(s)	Reason/Diagnosis

Child 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)

Name	Sex	Age	Living in the Home?	Health or Learning Problems
_____	☐Male ☐Female	_____	☐No ☐ Yes	_____
_____	☐Male ☐Female	_____	☐No ☐ Yes	_____
_____	☐Male ☐Female	_____	☐No ☐ Yes	_____
_____	☐Male ☐Female	_____	☐No ☐ Yes	_____

Any mental health history in the immediate or extended family?_____

_____

_____

Child Form

Childs Name: _____

CHILD'S CURRENT FUNCTIONING:

SLEEP

What is your child's typical bedtime? _____ What is your child's typical wake time? _____

Does your child have an established bedtime routine?_____

_____

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

_____

_____

PHYSICAL ACTIVITY

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

_____

_____

_____

TOILETING

Is your child toilet trained? ☐No ☐ Yes, since what age?: _____

Does your child have problems with bedwetting, daytime urine accidents or bowel movement soiling?

_____

_____

_____

MEDICAL AND DEVELOPMENTAL HISTORY:

PREGNANCY AND BIRTH HISTORY

How old was the birth mother when your child was born?: _____years

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

_____

Were there any complications during labor and delivery?: _____

_____

Child Form

Childs Name: _____

Did your child have any health problems following birth? _____

_____

MEDICAL HISTORY

Does your child have allergies to any medications?_____

_____

Has your child's vision been checked? ☐ No ☐ Yes Does your child wear glasses? ☐ No ☐ Yes

Describe any vision problems: _____

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 (Illness/Injury/Surgery/Hospitalization)

_____

_____

_____

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				

Child Form

Childs Name: _____

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?

Does your child have any oral motor problems, like late drooling, poor sucking, poor chewing?

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 child's social functioning or relationships?

Check all that apply to your child.

□ Engages in pretend play	□ Gets along well with other children	□ Has a good sense of humor
□ Gets along with adults	□ Acts aggressively towards others	□ Understands social cues
□ Has friends	□ Seems anxious around others	□ Feels uncomfortable or needs support
□ Keep friends	□ Understands gestures (i.e. pointing)	□ Has problems with peer pressure

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

Child Form

Childs Name: _____

BEHAVIOR MANAGEMENT

Do you have concerns about your child's behavior? _____
Who ordinarily disciplines your child? _____

How is your child disciplined?
☐Spanking ☐ Taking Away Privileges ☐ Sending to Room ☐Time-Out ☐ Talking or Reasoning
☐ Other: _____
Does it work? ☐ No ☐ Yes
Do adults caring for the child agree on discipline?_____
_____

EDUCATIONAL HISTORY

What school does your child 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? _____
_____

Child Form

Childs Name: _____

SUMMARY:

Anything else that you think is important for us to know about your child? _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form | Printed Name of Person Completing This Form

_____ _____/_____/_____

Relationship to Child | Date