Thank you for choosing WellSpan Behavioral Health as your healthcare provider. We view our relationship with you as a partnership in your healthcare needs. We have prepared the following guidelines in an effort to ensure that we provide healthcare services to you in a highly efficient manner. Our physicians, therapists, and staff look forward to assisting you with your healthcare needs.

- A physician from WellSpan Behavioral Health is on call 24 hours a day, 7 days a week.
- Employee Assistance Program (EAP) benefits may be available through your employer. The requested insurance information may not apply unless you continue beyond your EAP sessions.
- To avoid financial responsibility, you should contact your insurance company prior to your initial visit or if you change insurance companies during your treatment.
- Please bring in all insurance cards and photo identification to every visit.
- Billing services are provided by Physician Billing Services. Should you have any questions regarding your bill, please call (717) 851-6816
- Prescription refills and medication sample requests require three business days’ notice and are handled during our normal business hours.
- In the event of inclement weather, visit [www.wellspan.org/weather](http://www.wellspan.org/weather) to inquire if the office is delayed, closed or closing early. You may also contact the office prior to your appointment.
- WellSpan Behavioral Health is a fragrance-free facility; please do not wear any cologne or perfume to your appointments.

Completion of the following forms is necessary because of treatment needs, laws and governmental regulations. These forms should be completed with the patient’s information:

To be completed for patients 17 years and younger:

- Consent for Treatment
- Financial Policy
- Insurance Signature on File
- Medical Self-Report
- Personal History Form
- Cancellation/No Show Policy
- Developmental History
- Parental Consent For Psychiatry and Psychotherapy
- Pediatric Scale To Be Completed By Parent/Guardian
- Behavioral Scale To Be Completed By Teacher

Thank you for taking the time to complete these forms. Again, we look forward to assisting you with your healthcare needs. If you have any questions or concerns, please feel free to contact the office where your appointment is scheduled.
CONSENT FOR TREATMENT

WellSpan Behavioral Health affirms a dedication to value the individual rights of our clients. No procedures, policies, or treatment programs have been or will be designed to infringe on your rights as an individual. Your rights are:

You have the right to professional, respectful, and clinically appropriate care which is non-discriminatory with regard to age, race, religion, sex, ethnicity, color, national origin, marital status, sexual orientation, or handicap.

You have the right to obtain from the staff complete and current information concerning your diagnosis, treatment goals, and prognosis in understandable terms. You have the right to inspect your own medical record with the following limitations:

• Your primary clinician or the Clinical Director may temporarily remove portions of your record if it is determined that the release of such information may be harmful.
  
  Reasons for removing sections shall be documented, kept on file, and explained to you.

• You may request the correction or removal of inaccurate, irrelevant, outdated or incomplete information.

• You may submit rebuttal information or memoranda to be included in your own record.

• You may appeal a decision to limit your access to your record in writing to the Clinical Director.

You have the right to know criteria for admission, treatment, completion and discharge. You have the right to explanations regarding goals, procedures, and potential benefits of treatment explained to you. I understand that my participation in treatment is voluntary and I may terminate my treatment at any time by contacting the Behavioral Health office or my treating clinician.

You have the right to have all reasonable questions answered so that your consent to treatment of any type is informed. If significant alternative forms of treatment exist, you have the right to know the specific nature of proposed treatment and the expected duration of such treatment.

You have the right to privacy concerning your treatment program. Case discussion, consultation, examination, details divulged in group meetings, treatment, and appointment dates/times is strictly confidential. This information will not be divulged to anyone outside the agency, including your spouse, a significant other, or your parents (MH-children age 14+; D&A-no age restriction) without your written consent except in case of threat to self or others and/or report of abuse of a minor.

You have the right to request that within our capacity we will respond to your request for a specific service. An evaluation, service, or referral, at your request, will be made if deemed clinically appropriate. You will receive complete information prior to a clinical transfer concerning the need for such transfer.

You have the right to know of our continuing interest in you after discharge. We may be contacting you after discharge, by phone or mail.

You have the right to expect continuity of care. We will inform you of appointment times, services, and resources at discharge. You have the right to know what we believe are your continuing requirements for treatment post-discharge.

You have the right to file a complaint in writing to the Clinical Director if you feel that any of these rights have been violated.

You have the right to examine and receive an explanation of your bill regardless of the source of payment.

You have the right to know the names and positions of all individuals involved in your treatment.

You have the right to expect that WellSpan Behavioral Health staff will treat you and your family professionally. Any sexual contact or sexual harassment of clients is totally unacceptable. You have the right to alert the Clinical Director to inappropriate behaviors and statements. You may expect this matter to be addressed promptly and appropriately by the administration of this agency.

As a reciprocal component of your treatment at WellSpan Behavioral Health, you have certain responsibilities:

You have a responsibility to actively participate in your treatment, knowing your confidentiality will be respected per the aforementioned rights.

You have a responsibility to cancel an appointment with at least 24 hours advance notice if you are unable to attend.

You are responsible to not bring any potentially dangerous items (i.e., guns, knives, or weapons of any kind) on the premises.

You are responsible to attend your appointments substance free (alcohol/drugs) to best utilize your appointments. Your clinician is also mandated to be substance free as a condition of employment. You are responsible to conduct yourself appropriately (i.e., no assaultive behaviors, threats of violence, obscenities, or destruction of property). Failure to conduct yourself in an appropriate manner may constitute administrative discharge.

These rights and responsibilities provide the structure which governs the operations of WellSpan Behavioral Health.

With my signature below, I consent to treatment from Wellspan Behavioral Health.

__________________________________________________   __________________________________________________
Client Signature / Date                                   Witness Signature / Date

Rev. 6/12   ☐Patient offered copy and received           ☐Patient offered copy and declined
FINANCIAL POLICY

I. WHY IS IT IMPORTANT TO OUR PATIENTS?
   a. To provide our patients with an understanding of their financial responsibilities when receiving care.

II. PURPOSE
   a. To provide instructions on the usage of WellSpan Medical Group Financial Policy

III. PROCEDURE
   i. A copy of the WellSpan Medical Group Financial Policy should be made available to all patients.
   ii. Established patients should have a copy made available at their visit.
   iii. Any questions or concerns should be addressed by the designated person (i.e. Financial Representative or Practice Manager).

IV. OBTAINING THE FORM

The English version (Attachment A) can be ordered from the warehouse by requesting form # 9031.
The Spanish version (Attachment B) can be copied as needed from the attachment or by accessing the form on the “Q” drive.

Date Effective: September 1, 2002
Date Reviewed: April 18, 2008
Date Revised: April 17, 2003, November 14, 2005, July 9, 2013

Authorized by: Megan Lecas, WMG Vice President and Chief Operating Officer
Financial Policy

WellSpan Medical Group wants to provide our community with healthcare services and, at the same time, keep costs under control. To do this, we need your help. We ask you to read our payment policy listed below:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- You need to contact your insurance company with any questions about what they will cover.
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at 851-6816 at once so we can help you with this problem. Wellspan Medical Group will help to arrange a budget plan. If there is a need, we will help you to apply for Medical Assistance or our own Hardship Program.
- Any bill not paid by the date it is due will be sent to a collection agency.

IF YOU DO NOT HAVE HEALTH INSURANCE

Your Responsibility
- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility
- WellSpan Medical Group will provide the services you need, even if you cannot pay. We will not provide services if you are able to pay but choose not to pay.
- Patient Financial Representatives are available to discuss financial options with you.

IF YOU HAVE HEALTH INSURANCE

We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your employee health benefits.

If we DO participate with Your insurance plan (including Medicare):

Your Responsibility
- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance payment is due upon receipt of the statement, except for those from whom WellSpan Medical Group can not collect by law or agreement. If you do not pay we will begin collection efforts.

Our Responsibility
- We will send a bill to your insurance company for all services done in our offices.
If we DO NOT participate with your insurance plan:

Your Responsibility

I. You must pay for the service at the time it is given
   To make it simple, our office accepts cash, checks, VISA, MasterCard, Discover, MAC (debit), and bank drafts.
   We will charge you a $25.00 fee for any returned checks.

Our Responsibility

II. After you have paid us, we will send your bill to your insurance company. Your insurance will then pay you.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient who receives care and treatment from WellSpan Medical Group must pay any charges that are not paid by insurance or any other party.

Other providers, such as x-ray or laboratory, will bill the patient separately.

The patient must pay any amount not paid by insurance upon receipt of the statement.

revised: 10/01/02; 11/14/05
POLIZA FINANCIERA

El grupo médico de WellSpan desea proveer a nuestra comunidad servicios de cuidado de salud, y al mismo tiempo, mantener los gastos bajo control. Para hacer esto, necesitamos su ayuda. Le pedimos que lea nuestra política de pago descrita a continuación:

- Su cuenta se basa en los servicios que usted recibió. Usted es responsable de pagar la cuenta si su compañía de seguros no cubre todos los gastos.
- Lo qué su seguro médico cubre se basa en un acuerdo entre la compañía, o persona que le emplea, y la compañía de seguros.
- Usted necesita contactar a su compañía de seguros con cualquier pregunta sobre lo que cubrirá.
- Sabemos que los problemas financieros temporales pueden prevenir a veces de que usted haga un pago a tiempo de su cuenta. Si esto sucede, necesita contactarnos inmediatamente al 851-6816 para ayudarle con este problema. El Grupo Médico Wellspan le ayudará a hacer un plan de pago. Si es necesario, le ayudaremos a solicitar ayuda médica con nuestro propio programa de la dificultad.
- Cualquier cuenta no pagada en su fecha de vencimiento será enviada a una gencia de colección.

SI USTED NO TIENE SEGURO MÉDICO

Su Responsabilidad
- Usted debe pagar su cuenta entera a la hora de servicio o informarnos de su inhabilidad de pagar.

Nuestra Responsabilidad
- El grupo médico de WellSpan le proporcionará los servicios que usted necesita, incluso si usted no puede pagar. No proporcionaremos servicios si usted puede pagar pero elige no hacerlo.
- Están disponibles los representantes financieros para hablar de las opciones financieras con usted.

SI USTED TIENE SEGURO MÉDICO

Nosotros participamos con muchas compañías de seguros. Esto significa que hemos firmado un contrato con ellos para proporcionar el cuidado para las personas cubiertas. No son iguales todos los contratos, y es posible que ciertos servicios no sean cubiertos dependiendo de sus beneficios de salud como empleado.

Si participamos con su plan de seguro de salud (incluyendo Medicare):

Su Responsabilidad
- Usted debe pagar cualquier co-pago cuando recibe el servicio.
- Usted debe pagar cualquier deducible o cualquier cantidad que usted sepa es no cubierta al momento del servicio.
- Usted debe pagar la cantidad no pagada por su seguro el pago se vence al momento que recibe su factura, con la excepción de las cuales el grupo médico de WellSpan no puede cobrar por ley o acuerdo. Si usted no paga comenzaremos el proceso de colección.

Nuestra Responsabilidad
- Enviaremos una factura a su compañía de seguros por todos los servicios provistos en
Si no participamos con su plan de seguros:

Su Responsabilidad

I. Usted debe pagar el servicio al momento en que se proporciona
   - Para simplificarlo, nuestra oficina acepta el efectivo, cheques, VISA, MasterCard, Discover, MAC (débito), y giros bancarios.
   - Le cargaremos un honorario de $25.00 por cheques sin fondos

Nuestra Responsabilidad

II. Después de que usted nos haya pagado, le enviaremos su factura a su compañía de seguro.
   - Entonces su seguro le pagará.

DECLARACIÓN DE LA RESPONSABILIDAD FINANCIERA

El paciente que recibe cuidado y tratamiento del grupo médico de WellSpande debe pagar cargos que no son pagados por el seguro u otra parte.

Otros proveedores, como radiografías o laboratorio, enviarán la factura al paciente por separado.

El paciente debe pagar cualquier cantidad no pagada por el seguro al recibir la factura.
INSURANCE SIGNATURE ON FILE

PATIENT’S NAME ____________________________________ DOB# ___________________

INSURANCE COVERAGE

I request that payment of authorized Commercial Benefits, Medicare or Secondary Medicare coverage benefits be made directly to the WellSpan Medical Group for any services furnished to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

__________________________________                  ________________________________________
Primary Identification Number                                     Secondary Identification Number

__________________________________      ________________________________________
Primary Insurance        Secondary Insurance

__________________________________    _________________________________________
Today’s Date        Signature of Patient (or Parent, if patient is a minor)

******************************************************************************************

Rev. 4/15/11
MEDICAL SELF-REPORT

Date of Birth __________/__________/__________  Date Completing this Form __________/__________/__________

1. Whom shall we notify in case of emergency?  
   a. What is this person’s phone number? (________________) __________________ - __________________
   b. How is this person related to you?  

2. Name of Family Physician: __________________________________________  Date of Last Exam __________/__________/__________

3. Do you have any medical concerns at the present time?  □ No  □ Yes  If “yes,” please describe: __________________________________________________________

4. Please list all medications that you are currently taking, including both physician-prescribed and over-the-counter medications (aspirin, laxatives, vitamins, herbal supplements, diet pills, etc.).  Clinicians: add addendum if needed.

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSAGE &amp; DIRECTIONS</th>
<th>TAKING AS PRESCRIBED?</th>
<th>HOW LONG HAVE YOU TAKEN?</th>
<th>WHO PRESCRIBES?</th>
<th>SIDE-EFFECTS?</th>
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</table>

5. Please list any prior medications that you have taken:

6. Are you exposed to any chemicals (acids, alkalis, detergents, toxic sprays, poisons, etc.) at work, home or with hobbies?  
   □ No  □ Yes: __________________________________________________________

7. Are you allergic to any medications or environmental substances (i.e. pollen, molds, etc.)?  
   □ No  □ Yes: __________________________________________________________

8. Are you up to date on your immunizations and TB tests?  □ No  □ Yes

9. Do you want a referral to a family doctor/primary care physician?  □ No  □ Yes

10. Have you had any unexpected weight gain or weight loss within the past 3 months?  □ No  □ Yes: __________________________

11. Do you experience physical pain that interferes with your daily activities?  □ No  □ Yes: __________________________

12. Information about recent falls, clumsiness, head injury:  
   a. Have you fallen recently?  □ No  □ Yes  
   b. If yes, are issues about falling being addressed by anyone?  □ No  □ PCP  □ Psychiatrist  □ Other ______________________
   c. If completing this form for a child/adolescent, has there been an increase in falling or clumsiness lately?  □ No  □ Yes  
   d. If yes, has there been: □ a change in medication?  □ Other explanation: ________________________________  
      Clinicians: If fall risk identified, implement departmental-specific fall precautions.  
   e. Have you ever had a head injury or lost consciousness?  □ No  □ Yes: Explain ________________________________

13. Do you use caffeine (coffee, tea, cola, iced tea, chocolate) more than four (4) times a day?  □ No  □ Yes

14. Do you smoke cigarettes, pipes, cigars or chew tobacco?  □ No  □ Yes

15. In the past year have you consumed five (5) or more alcoholic drinks (beer, wine, liquor) on any single occasion?  □ No  □ Yes
16. Have you ever used drugs other than those prescribed for you by a physician?  
- [ ] No  
- [ ] Yes

17. If you answered “yes” to question 12, 13, 14 and/or 15, please complete the following chart regarding your current and past use of substances. Include caffeine, tobacco, alcohol and street drugs, as well as any abuse of over-the-counter or prescribed medications:

<table>
<thead>
<tr>
<th>NAME OF DRUG</th>
<th>FREQUENCY</th>
<th>QUANTITY</th>
<th>LAST USE</th>
<th>DURATION OF USE</th>
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18. Are you currently taking or have you taken any of the following in the past year?
- [ ] pain medication  
- [ ] heart pills  
- [ ] blood thinning pills  
- [ ] herbal therapy  
- [ ] antibiotics  
- [ ] HIV medication  
- [ ] steroids or cortisone  
- [ ] blood pressure pills  
- [ ] insulin  
- [ ] vitamins  
- [ ] hormones  
- [ ] medication for  
- [ ] weight loss pills  
- [ ] medications for TB  
- [ ] anti-depressants  
- [ ] tranquilizers  
- [ ] thyroid pills  
- [ ] Hepatitis (Interferon)

19. Family Medical History – To the best of your knowledge, please put a ✓ if you have or anyone in your family has had the following:

<table>
<thead>
<tr>
<th>Anemia</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Cancer</th>
<th>Dementia</th>
<th>Diabetes</th>
<th>Eating Disorder</th>
<th>Emphysema</th>
<th>Epilepsy</th>
<th>Heart Problems</th>
<th>Irritable Bowel</th>
<th>HIV/AIDS</th>
<th>Kidney Problems</th>
<th>Mental Illness</th>
<th>Migraines</th>
<th>Substance Abuse</th>
<th>Thyroid Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
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20. In addition to what is listed above, please list any serious health problems and/or hospitalizations you have had in the past including dates and a brief description: ____________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

FOR OFFICE USE ONLY:

Intake Clinician Signature and Credentials ___________________________ Date ____________

I.A. pg 6 - 1.2013 AJS
PERSONAL HISTORY FORM

If Patient is under 18 years old, please complete:

<table>
<thead>
<tr>
<th>Parents' Names</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>May we call you at work?</th>
</tr>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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</tbody>
</table>

1. Why are you seeking treatment at this time?  
Today's Date ______/______/_______

2. Have you had any previous mental health or substance abuse treatment such as Inpatient Psychiatric Hospitalization, Detox, Residential Rehab, Partial Hospitalization, Intensive Outpatient, Outpatient? □ No □ Yes
If you checked "yes," please complete the following chart:

<table>
<thead>
<tr>
<th>When?</th>
<th>Where?</th>
<th>For what problem?</th>
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</table>

3. Are you currently receiving mental health or substance abuse treatment elsewhere? □ No □ Yes
If you checked "yes," please list the type of services you receive and where you receive them:
________________________________________________________________________________________________________

4. Are any of the following services or agencies currently involved in your life and/or providing you with services?
□ Children and Youth □ Probation/Parole □ MH/MR □ York Co. D&A □ Domestic Relations □ Social Security □ OVR □ Other agencies/services: _____________________________________________________________________________________

5. What is your current support system? □ Family □ Friends □ Support Group □ Religious organization □ No support system □ Other: ____________________________________________________________________________

6. What is the attitude of your primary social support person(s) regarding your desire to participate in our services?
□ Supportive □ Willing to be involved □ Non-supportive □ Opposed to my seeking help □ I have no support system □ Please describe: _______________________________________________________________________________________________________

7. Are you being or have you ever been threatened or abused by anyone? □ No □ Yes
If yes, please check below and state who is threatening/abusing you:

□ Physical: □ Verbal:
□ Sexual: □ Emotional:
**VOCATIONAL STATUS:**

<table>
<thead>
<tr>
<th>Employed Full-Time</th>
<th>Employed Part-Time</th>
<th>Assigned Temporary Work</th>
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</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>Disabled/On Disability</td>
<td>Retired</td>
</tr>
<tr>
<td>Student</td>
<td>On Leave-of-Absence</td>
<td>Laid-Off</td>
</tr>
</tbody>
</table>

I am presently:

- □ Employed Full-Time
- □ Employed Part-Time
- □ Assigned Temporary Work
- □ Unemployed
- □ Disabled/On Disability
- □ Retired
- □ Student
- □ On Leave-of-Absence
- □ Laid-Off

**FACTORS AFFECTING LEARNING:**

8. What is the highest grade you completed in school? _______________________________________________________________

9. What language(s) do you speak?  
   - □ English  
   - □ Spanish  
   - □ Other: ___________________________________

10. What language(s) do you read?  
    - □ English  
    - □ Spanish  
    - □ Other: ___________________________________

11. Do you need an interpreter?  
    - □ No  
    - □ Yes _______________________________________

12. Do you have any physical disabilities?  
    - □ No  
    - □ Yes _______________________________________

13. Do you wear/need contacts or glasses?  
    - □ No  
    - □ Yes _______________________________________

14. Do you wear/need hearing aides?  
    - □ No  
    - □ Yes _______________________________________

15. Do strong feelings make it hard for you to learn?  
    - □ No  
    - □ Yes _______________________________________

16. Do you have any cultural or religious practices that may impact your treatment?  
    - □ No  
    - □ Yes _______________________________________

   If "yes," briefly describe: ________________________________________________________________________________

17. **OPTIONAL:** In order for us to provide culturally-sensitive treatment, please indicate to which race/ethnic group(s) you belong:
   - □ African-American/Black
   - □ Alaskan Native
   - □ American Indian
   - □ Asian or Pacific Islander
   - □ Caucasian/White
   - □ Cuban
   - □ Mexican
   - □ Puerto Rican
   - □ Other Hispanic/Latino
   - □ Other:

18. What is the best way for you to learn new things?  
    - □ Verbal instruction  
    - □ Audiovisual (hearing and seeing)  
    - □ Written instruction  
    - □ All types

**PLEASE CHECK ANY OF THE FOLLOWING THAT ARE CURRENTLY PROBLEMS FOR YOU:**

- □ Family Problems (i.e. death of family member, health problems in family, arguments in family, abuse in family, divorce, separation, etc.)
- □ Social/Friendship Problems (i.e. death or loss of friend, lack of social support, isolated from others, discrimination, don’t get along well with others, etc.)
- □ Job or School Problems (i.e. unemployment, stressful schedule, poor work. school conditions, job dissatisfaction, don’t get along with boss/teachers or co-workers/classmates, etc.)
- □ Housing Problems (i.e. homeless, poor housing conditions, unsafe neighborhood, problems with neighbors, problems with landlord, etc.)
- □ Money Problems (i.e. cannot pay bills, not enough money for basic necessities like food, shelter, clothing, excessive debt, bankruptcy, etc.)
- □ Problems with Health Care (i.e. do not have a doctor, don’t have a way to get to appointments, don’t have health insurance, cannot obtain needed medication, etc.)
- □ Legal Problems (i.e. involved in court, on probation or parole, victim of a crime, pending lawsuit, DUI, etc.)
- □ Gambling Problems (lack of control, being deceptive about the amount spent or frequency of gambling)

**PLEASE CONTINUE ON WITH THE MEDICAL SELF-REPORT ➔**

**FOR OFFICE USE ONLY:**

Intake Clinician Signature and Credentials
Date
Acknowledgement of Behavioral Health No-Show Policy

As part of our ongoing efforts to provide timely and efficient access to care it is very important that we have 24 hour notice if you are unable to keep your scheduled appointment.

Please be advised that failure to notify the office when unable to keep a scheduled appointment may result in—

Loss of future appointments
A fee for the missed appointment
Discharge from Behavioral Health Services

Patient name: ________________________ DOB ____________________

Patient/Parent signature ___________________________ Date ________

Acknowledgement of Prescription Refill Policy

Please contact your pharmacy regarding medication refill requests. Your pharmacy will notify our office of your request. Please be advised that we require 72 hour notice to process medication refill requests.

Patient name: ________________________ DOB ____________________

Patient/Parent signature ___________________________ Date ________

☐ Patient offered copy and received
☐ Patient offered copy and declined
**Developmental History – WellSpan Behavioral Health**
Please complete on all patients 17 years old and younger

<table>
<thead>
<tr>
<th>Name of child:</th>
<th>MRN:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informant:</td>
<td>Relationship:</td>
<td></td>
</tr>
<tr>
<td>Mother’s health during pregnancy:</td>
<td>Good</td>
<td>Fair</td>
</tr>
<tr>
<td>Any illness/complications during pregnancy (i.e.: R.H. neg, toxemia, diabetes, etc.)?</td>
<td>No</td>
<td>Yes:</td>
</tr>
<tr>
<td>Any substance use/abuse before or during pregnancy?</td>
<td>No</td>
<td>Yes:</td>
</tr>
</tbody>
</table>

**Delivery**

<table>
<thead>
<tr>
<th>Length of pregnancy:</th>
<th>months</th>
<th>Labor:</th>
<th>hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of delivery:</td>
<td>Vaginal</td>
<td>Cesarean</td>
<td></td>
</tr>
<tr>
<td>Birth weight:</td>
<td>lbs.</td>
<td>oz.</td>
<td></td>
</tr>
<tr>
<td>Complications?</td>
<td>No</td>
<td>Yes specify:</td>
<td></td>
</tr>
</tbody>
</table>

Child’s condition after birth: ________________________________________________________________________________________________

**Early Development**

<table>
<thead>
<tr>
<th>Age</th>
<th>Difficulties? Please Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walked</td>
<td></td>
</tr>
<tr>
<td>First Word Spoken</td>
<td></td>
</tr>
<tr>
<td>Sentences formulated</td>
<td></td>
</tr>
<tr>
<td>Toilet Trained</td>
<td></td>
</tr>
</tbody>
</table>

Any unusual childhood illnesses? | No | Yes Specify: |

Child raised by parents? | Yes | No | Specify: |

Any child care arrangements | None | Babysitter | Daycare | Grandparents | Other | Specify: |

Any child care difficulties? | No | Yes | Specify: |

Any long separation from the primary care giver? | No | Yes | Specify: |

Any social/behavioral problems? | No | Yes | Specify: |

Describe child’s temperament:__________________________________________________________________________________________

Intake Clinician Signature and Credentials

I.A. (C&A) only pg 7 - 1.2013 AJS
PARENTAL CONSENT FOR SERVICES AT WELLSPAN BEHAVIORAL HEALTH

Child’s Name __________________________ Date of Birth _____/_____/_____

Your child, named above, has been referred for psychiatry and/or psychotherapy services at WellSpan Behavioral Health. We are looking forward to starting a positive working relationship in helping your child through his/her current difficult times. Your show of support in the well-being of your child is necessary before we can begin services. As such, we are requesting your consent for your child to participate in

- Psychiatry Services
- Psychotherapy Services

Please complete the following information:

Your Name: __________________________

Relationship to child: ______________________ Phone: __________________________

My signature acknowledges that I consent to have my child receive psychiatry and/or Psychotherapy services at WellSpan Behavioral Health. I understand that I may revoke my consent by submitting a request in writing to WellSpan Behavioral Health at the address indicated below.

_____/_____/_____

Parent’s Signature

Date

Once completed, please return this form to the following office:

- WellSpan Behavioral Health
  Meadowlands Office Center
  3550 Concord Road
  York, PA 17402
  717-851-6340

- WellSpan Behavioral Health
  40 V-Twin Drive
  Suite 202
  Gettysburg, PA 17325

- WellSpan Behavioral Health
  781 Far Hills Drive
  Suite 600
  New Freedom, PA 17349

- WellSpan Behavioral Health
  1600 South George Street
  York, PA 17402
  717-812-4200

Failure to return this form in a timely manner may delay necessary treatment. We appreciate your cooperation in this matter

01.2013 AJ S
### Child / Adolescent Behavior Scale

**Child’s Name**

**Child’s Date of Birth**

**Date Completed**

**Completed By**

---

**Please circle the number which best describes your child’s behavior within the past two months.**

0 = Not at all  
1 = Sometimes  
2 = Often  
3 = Very Often

<table>
<thead>
<tr>
<th>Behavior</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not pay attention to details; makes careless mistakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has difficulty keeping attention on current activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appears to not listen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not follow through with instructions; does not finish task</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has difficulty organizing tasks and activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoids or dislikes activities which require concentration for extended</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>periods of time (i.e. homework)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials necessary for doing task are often scattered, lost or damaged</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily distracted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forgetful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fidgets with hands or feet; squirmy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not remain seated when expected to do so</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessively runs and climbs where inappropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has difficulty playing quietly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appears as if to be “driven by a motor”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks excessively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurs out answers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has difficulty awaiting turn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interrupts others too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loses temper</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently argues with parents / authority figures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defies or refuses to comply with adults’ request</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picks on others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blames others for mistakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily annoyed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often angry or resentful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often spiteful or vindictive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullies, threatens or intimidates others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starts physical fights</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has used a weapon that can cause serious physical harm to another</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physically cruel to people or animals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steals from others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forces another into sexual activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has intentionally set a fire</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has intentionally destroyed property</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has broken into house, building or car</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Lies/cons others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has stolen from stores</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Stays out at night without permission</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has run away from home overnight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has skipped school</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Often anxious or worried</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unable to control worry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feels restless or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Easily fatigues</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty concentrating; mind goes blank</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Often irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Often feels tense</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feels depressed or irritable most days</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not interested in having fun</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Has lost or gained weight</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unable to sleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sleeps too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feels worthless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feels guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Recurrent thoughts of death</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
**PERFORMANCE:**

### Academic Performance

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Above</th>
<th>Average</th>
<th>Somewhat of a Problem</th>
<th>Problematic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reading</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Mathematics</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Written Expression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Classroom Behavioral Performance

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relationship with peers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Following directions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Disrupting class</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Assignment completion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Organizational skills</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please return this form to:

**For Office Use Only**

- Total number of questions scored 2 or 3 in questions 1–9: __________
- Total number of questions scored 2 or 3 in questions 10–18: __________
- Total Symptom Score for questions 1–18: __________
- Total number of questions scored 2 or 3 in questions 19–28: __________
- Total number of questions scored 2 or 3 in questions 29–35: __________
- Total number of questions scored 2 or 3 in questions 36–43: __________
- Average Performance Score: __________
<table>
<thead>
<tr>
<th>How to score the teacher checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.  For questions 1–9, add up the number of questions where the teacher circled a 2 or 3.</td>
</tr>
<tr>
<td>B.  For questions 10–18, add up the number of questions where the teacher circled a 2 or 3.</td>
</tr>
<tr>
<td>C.  For questions 36–43, add up the number of questions where the teacher circled a 4 or 5.</td>
</tr>
</tbody>
</table>

ADHD Predominantly Inattentive subtype (1 and 2):
- At least 6 of questions 1–9 must score a 2 or 3 and
- At least 1 of questions 36–43 must score a 4 or 5

ADHD Predominantly Hyperactive/Impulsive subtype
- At least 6 of questions 10–18 must score a 2 or 3 and
- At least 1 of questions 36–43 must score a 4 or 5

ADHD Combined Inattention/Hyperactivity subtype
- At least 6 of questions 1–9 must score a 2 or 3 and
- At least 6 of questions 10–18 must score a 2 or 3 and
- At least 1 of questions 36–43 must score a 4 or 5