Dear Parent or Guardian,

Thank you for choosing Stanbro Healthcare Group for your child's care. Per your request, I am sending you the new patient Intake packet.

We have a detailed intake process that is designed to improve efficiency and provide the best service possible. In order to set up an appointment and receive an appropriate evaluation for your child, we ask that you carefully fill out all of the enclosed forms as completely as possible and return them via email, fax or US mail to the address provided below. Once we receive your packet, our team will review the information for the appropriate clinician and appointment. You will be contacted by one of our placement team members as soon as an appointment date becomes available.

Enclosed are the following:

1. Demographic Sheet
2. Child History Questionnaire
3. The SNAP-IV Teacher and Parent Rating Scale
4. Release of Information
5. Consent for Treatment & Patient Rights

Please include when returning:

1. A copy of the front and back of your child's insurance card(s)
2. If possible, a copy of your child's most recent physical exam, immunization record and relevant lab results

Methods for returning your completed packet:

- Fax: 405.341.2672
- Email: Info@StanbroHealthcareGroup.com
- US Mail: 2000 East 15th Street, Suite 400A, Edmond, OK 73013
- Coming soon to our website: StanbroHealthcareGroup.com

Again, thank you for choosing Stanbro Healthcare Group. We are honored to serve you and your child.

Sincerely,

The SHG Team

INFORMATION ALL PARENTS SHOULD KNOW ABOUT
MENTAL HEALTH INSURANCE COVERAGE

Stanbro Healthcare Group provides in-network services for a wide variety of insurance providers. We also provide documentation of billing and services if you prefer out-of-network coverage. **We are not contracted with and do not accept Medicare**.

Please note that mental health coverage is frequently very different from medical coverage. Also benefits allowed by your insurance provider are frequently subject to change beyond our control. We strongly encourage you to contact your insurance provider or benefits administrator to verify the specific mental health services allowed by your insurance plan.

- **Verification of mental health benefits and preauthorization for services:** As a courtesy to you, we obtain information regarding your mental health benefits and preauthorization before your first visit. You will be provided with the information we are given by your health plan and we encourage you to refer to your policy manual or call your plan to confirm the information provided to us.

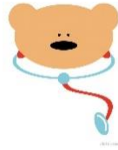
- **Co-payments:** Costs are often a percentage of the charges incurred instead of a fixed dollar amount. Information about co-payments for mental health services is rarely listed on the insurance card and is obtained by calling the plan.

- **Deductibles:** Mental health services are often separate and in addition to the medical deductible outlined by your insurance plan. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

- **Referrals:** If your child is covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your child's primary care physician prior to your visit (Tricare plans require this referral). *Please note that a written referral is a requirement of the insurance company and that we must adhere to the plan's administrative requirements in order to receive payment on your behalf.*

- **Limits:** Frequently, mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

- **Testing:** Neuropsychological, psychological, and developmental testing are frequently requested by our clinicians and referrals will be made for the needed testing. Most insurance companies limit the number of testing hours covered. Please contact your insurance provider prior to the referral being placed to verify limits and coverage.



STANBRO HEALTHCARE GROUP LLC

DEMOGRAPHICS

______________________________ Patient's Name (Last, First, MI)

______________ Patient's Date of Birth

__________ Sex

__________ Gender Identity

__________ Race

______________ Social Security Number

______________________________ Mailing Address

____

______________________ Home Telephone

______________________ Cell Number

______________________________ Email Address

Preferred method of contact for appointment reminders and other electronically generated messages

□Voice □ Text □ Email

REASON FOR SEEKING MENTAL HEALTH SERVICES (check all that apply)

- □ Behavior Problems
- □ Attention Deficit/Hyperactivity Disorder
- □ Depression
- □ Anxiety
- □ Autism
- □ PANDAS/PANS
- □ Obsessive Compulsive Disorder
- □ Oppositional Defiant Disorder
- □ Suicidal Ideation
- □ Homicidal Ideation
- □ Visual Hallucinations
- □ Audible Hallucinations
- □ Developmental Evaluation
- □ Custody/Court/Legal
- □ Other

WHO REFERRED YOU TO STANBRO HEALTHCARE GROUP?

- □ Pediatrician/Primary Care
- □ Specialist (indicate specialty) ________________
- □ School
- □ Therapist/Counselor
- □ Social Worker/Case Worker
- □ Emergency Room
- □ General Hospital Discharge
- □ Psychiatric Hospital Discharge
- □ Self-referred

INSURANCE INFORMATION

Primary Insurance Company: ______________________________Telephone Number________________

Member Identification Number: ____

Group Name: ______________________________Group Number: ______________________

Subscriber's/Policy Holder's Name: ____

Subscriber's/Policy Holder's Date of Birth: ____________________Social Security Number: __________________

Secondary Insurance Company: ______________________________Telephone Number________________

Member Identification Number: ____

Group Name: ______________________________Group Number: ______________________

Subscriber's/Policy Holder's Name: ____

Subscriber's/Policy Holder's Date of Birth: ____________________Social Security Number: __________________

DEMOGRAPHICS CONTINUED

FINANCIALLY RESPONSIBLE PARTIES (GUARANTORS)

Primary Guarantor's Name: ______________________________
Relationship to Patient: ______________________________
Address (if different from patient): ______________________________
____
Employer: ______________________________
Address: ______________________________
Home Telephone: ______________ Cell Number: ______________
Work Telephone: ______________ Email: ______________
Date of Birth: ______________ Social Security Number: ______________
Secondary Guarantor's Name: ______________________________
Relationship to Patient: ______________________________
Address (if different from patient): ______________________________
____
Employer: ______________________________
Address: ______________________________
Home Telephone: ______________ Cell Number: ______________
Work Telephone: ______________ Email: ______________
Date of Birth: ______________ Social Security Number: ______________

SCHOOL INFORMATION

____
Name of School
Telephone Number: ______________ Current Grade: ________ IEP (YES/NO): ________

______________________ ______________________
Teacher's Name Counselor's Name

ARE THERE OTHER FAMILY MEMBER'S WHO ARE CURRENT PATIENTS AT STANBRO HEALTHCARE GROUP?

□ Yes (please list below and provider they see) □ No

____
____

CHILD'S HISTORY QUESTIONNAIRE

Child's Full Name Date of Birth

Name of person completing this questionnaire and relationship Today's Date

CONTACT INFORMATION

Parent / Legal Guardian's (Please circle one) Full name Date of Birth

Address

Phone Number Profession and/or work activity

Parent / Legal Guardian's (Please circle one) full name Date of Birth

Address

Phone Number Profession and/or work activity

Other primary caregiver/ legal guardian full name Date of Birth

Address

Phone Number Profession and/or work activity

EMERGENCY CONTACT

Name Phone Number

Address

What are the main concerns that you have about your child? (**REQUIRED**)

____
____
____
____
____
____
____
____
____

CHILD'S RACE/ETHNICITY

☐ American Indian/Alaska Native ☐ Asian: Indian/Pakistani ☐ Asian: Chinese
☐ Asian: Other (specify) ____________ ☐ Hispanic or Latino ☐ Black/African American
☐ White/Caucasian ☐ Other (specify) ______________

CHILD'S RELIGION

☐ Buddhist ☐ Christian Catholic ☐ Christian Protestant ☐ Hindu
☐ Jewish ☐ Muslim ☐ Other ☐ None

Is the child adopted? ☐ Yes ☐ No

Other children in the family?

Name	Gender	Date of Birth	Age	Relation to child

Other persons living in the home (significant other, friend, grandparents, foster child, etc.)

Name	Gender	Date of Birth	Age	Relation to child

LANGUAGES SPOKEN IN THE HOME ______________________________________

LIST ANY AGENCIES OR PROFESSIONALS CURRENTLY PROVIDING SERVICES TO YOUR CHILD AND FAMILY:

Agencies or professional	Age of child when services began

PREGNANCY HISTORY

During pregnancy with this child did the mother experience any of the following?

□ Medical problems ______________________________

□ Special diet ______________________________

□ Medications ______________________________

□ Full-term (38-42 weeks) □ Other than full-term ______________________________

Number of weeks at birth: __________ Any accidents/injuries? □ No □ Yes ______________________________

____

____

____

BIRTH HISTORY

Age of mother at birth of child? ____________ Complications for mother during delivery? □ No □ Yes __________

____

____

____

Child's birth weight: ______________ Was Oxygen needed? □ No □ Yes ______________________________

____

____

Special care? □ No □ Yes ______________________________

____

____

How long did the child stay in the hospital after birth? ______________________________

How long did the mother stay in the hospital after birth? ______________________________

Describe your child in the first 6 months:

Easy baby	□ No	□ Yes
Enjoys people	□ No	□ Yes
Irritable	□ No	□ Yes
Difficult to sooth	□ No	□Yes
Sleep/wake cycle poorly regulated	□ No	□ Yes
Unusually quiet	□ No	□ Yes
Unusually sick	□ No	□ Yes
Feeding difficulties	□ No	□ Yes
Strong reaction to light/sound/touch	□ No	□ Yes
Colic	□ No	□ Yes

FAMILY HISTORY

Please list any medical or psychiatric illness in your family:

____

____

____

____

____

____

____

____

____

CHILD'S EARLY DEVELOPMENT (specify age)

Sat without support ________
Crawled ________
Walked without support ________
Used single words (other than mama or papa) ________
Used 2-3 word sentences ________
First began to sleep through the night ________
Daytime wetting stopped ________
Bed-wetting stopped ________
Bowel control ________

CHILD'S MEDICAL HISTORY

Health Care Providers:

____
Child's Primary Care Physician

____
Address

______________________ ______________________
Phone Number Fax Number

Date of last complete physical examination: ______________________

Does your child have any allergies (environmental, food, medication)? □ No □ Yes ______________

____
____
____

Does your child take any medications (include vitamins, over the counter drugs, and herbal medications)

□ No □ Yes

Name	Dosage	Frequency	Date Began

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write what you do remember).

Antidepressants	**Dates**	**Dosage**	**Response/Side-Effects**
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			

Other

Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)_			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			

Sedative/Hypnotics	Dates	Dosage	Response/Side-Effects
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

ADHD Medications	Dates	Dosage	Response/Side-Effects
Vistaril___________			
Other____________			

Antianxiety Medications	Dates	Dosage	Response/Side-Effects
Busbar (buspirone)			
Other____________			

Has your child ever been hospitalized for any reason? □ No □ Yes

Reason	Date	Place	Length of stay

Does your child have a current or past history of any of the following:

Head injury	□ No	□ Yes	
Broken bones	□ No	□ Yes	
Surgeries	□ No	□ Yes	
Birth defects	□ No	□ Yes	

Poisoning ☐ No ☐ Yes ______
Heart problems ☐ No ☐ Yes ______
Kidney problems ☐ No ☐ Yes ______
Liver disease ☐ No ☐ Yes ______
Lung disease ☐ No ☐ Yes ______
Blood disease ☐ No ☐ Yes ______
Cancer ☐ No ☐ Yes ______
Seizure ☐ No ☐ Yes ______
Other neurological problems ☐ No ☐ Yes ______
Genetic disorder ☐ No ☐ Yes ______
Diabetes ☐ No ☐ Yes ______
Thyroid ☐ No ☐ Yes ______
Skin problems ☐ No ☐ Yes ______
Lyme disease ☐ No ☐ Yes ______
Impaired sight ☐ No ☐ Yes ______
Impaired hearing ☐ No ☐ Yes ______
Speech difficulty ☐ No ☐ Yes ______
Sleeping difficulty ☐ No ☐ Yes ______
Eating disorder ☐ No ☐ Yes ______
Sleep Apnea ☐ No ☐ Yes ______
Severe vomiting ☐ No ☐ Yes ______
Choking events ☐ No ☐ Yes ______
Other problems ☐ No ☐ Yes ______

Childhood Diseases (child's age in years)
Chicken Pox ☐ No ☐ Yes Age ______
German Measles/Rubella ☐ No ☐ Yes Age ______
Measles ☐ No ☐ Yes Age ______
Scarlet Fever ☐ No ☐ Yes Age ______
Whooping Cough ☐ No ☐ Yes Age ______
Strep throat ☐ No ☐ Yes Age ______

SOCIAL DEVELOPMENT
Does your child make friends easily? ☐ No ☐ Yes
Does your child have difficulty interacting with other children? ☐ No ☐ Yes
Does your child have difficulty interacting with adults? ☐ No ☐ Yes
Does your child have a "best friend?" ☐ No ☐ Yes

BEHAVIORAL DEVELOPMENT
Does your child exhibit aggression to people or animals? ☐ No ☐ Yes If yes, please explain ______
______
Does your child often bully, threaten or intimidate others? ☐ No ☐ Yes If yes, please explain ______
______
Has your child deliberately destroyed others' property? ☐ No ☐ Yes If yes, please explain ______
Does you child often lie to obtain goods or favors or to avoid obligations? ☐ No ☐ Yes If yes, please explain ______
______
Has your child ever ran away from home? ☐ No ☐ Yes If yes, please explain ______
______
Is your child often truant from school? ☐ No ☐ Yes If yes, please explain ______
______

PRESCHOOL/SCHOOL HISTORY

Is your child attending preschool/school? □ No □ Yes

If yes, name of school ____________________ Grade __________

Does your child attend any special classes or receive any special education services? □ No □ Yes

If yes, please name ____________________

Has your child ever repeated a grade in school or been "held-back" for any reason? □ No □ Yes

If yes, please explain: ____________________

Does your child have any learning or behavioral problems in school? □ No □ Yes

If yes, please explain: ____________________

SLEEP HABITS

What time does your child generally go to bed? __________pm/am

What time does your child generally wake up? __________pm/am

On average, how may hours does your child sleep per night? __________hours

Does your child snore or seem to gasp for air during the night? □ No □ Yes

STRESSORS

Is your child facing significant stressors at this time? □ No □ Yes

If yes, please describe: ____________________

Is your family facing any significant stressors at this time? □ No □ Yes

If yes, please describe: ____________________

Is there anything else you would like us to know that would assist us in understanding your child? ____________________

SNAP-IV TEACHER AND PARENT RATING SCALE

James M. Swanson, Ph.D., University of California, Irvine CA 92715

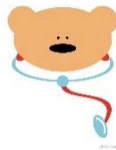
Name ____________ Gender ______ Age/Date of Birth ______

Completed by ____________ Date ______ Rx ______

For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
TOTAL **INNATTENTION AVERAGE SCORE (TOTAL/9) (2.56; 7.18P)**				
10. Often fidgets with hands or feet or squirms in seat				
11. Often leaves seat in classroom or in other situations in which remaining seated is expected				
12. Often runs about or climbs excessively in situations in which it is inappropriate				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Often is "on the go" or often acts as if "driven by a motor"				
15. Often talks excessively				

For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
16. Often blurts out answers before questions have been completed				
17. Often has difficulty awaiting turn				
18. Often interrupts or intrudes on others (e.g., butts into conversations/games)				
TOTAL				
HYPERACTIVE/IMPULSIVE AVERAGE SCORE (TOTAL/9) (1.78T;1.44P)				
19. Often loses temper				
20. Often argues with adults				
21. Often actively defies or refuses adult requests or rules				
22. Often deliberately does things that annoy other people				
23. Often blames others for his or her mistakes or misbehavior				
24. Often touchy or easily annoyed by others				
25. Often is angry or resentful				
26. Often is spiteful or vindictive				
TOTAL				
ODD AVERAGE SCORE (TOTAL/8) (1.38T; 1.88P)				
27. Has difficulty getting started on classroom assignments				
28. Has difficulty staying on task for an entire classroom period				
29. Has problems in completion of work on classroom assignments				
30. Has problems in accuracy or neatness of written work in the classroom				
31. Has difficulty attending to a group classroom activity or discussion				
32. Has difficulty making transitions to the next topic or classroom period				
TOTAL				
ACADEMIC AVERAGE SCORE (TOTAL/6)				

For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
33. Has problems in interactions with peers in the classroom				
34. Has problems in interactions with staff (teacher or aide)				
35. Has difficulty remaining quiet according to classroom rules				
36. Has difficulty staying seated according to classroom rules				
TOTAL				
DEPORTMENT AVERAGE SCORE (TOTAL/4)				
ADHD AVG SCORES (IN; H-I)				
ADHD-C AVERAGE SCORE (TOTAL/2) (2.00T; 1.67P)				



AUTHORIZATION OF RELEASE OF INFORMATION

I, the parent/guardian of ____________________________________, hereby consent to and to authorize Stanbro Healthcare Group to □ release to □ release from:

______________________________ ______________________________

Physician Name Facility/Group Name

____

Address, City, State, Zip

______________________________ ______________________________

Telephone Number Fax Number

The following information:

□ Psychiatric Records	□ Psychological/Educational Assessments	□ Psychosocial Assessment
□ ARD Materials	□History of Allergies	□ Last Report Card, Consumer's Forms
□ Medication/Lab Data EKG	□ Last Physical Examination	□ Immunization Records
□ Entire Health Record	□ Other: ______________________	

I also understand that my insurer requires information regarding my child's treatment; I agree to have this information released as requested. I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to the information already retained; used or disclosed in response to this authorization. The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal law (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the patient or is permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

_____ Initial Here: I understand that if my records are released, I will be charged a $25.00 Records Request Fee, payable prior to the release of the requested records. Your health insurance coverage will not reimburse you for this charge.

______________________________ ______________________________

Patient Signature Date of Birth

______________________________ ______________________________

Social Security Number Expiration Date (if not one year of signature date)

______________________________ ______________________________

Name of Parent/Legal Guardian Date

____

Signature of Parent/Legal Guardian

______________________________ ______________________________

Witness Date

Stanbro Healthcare Group
2000 East 15th Street, Suite 400A
Edmond, OK 73013
405.341.1697 f405.341-2672

HIPPA Document
6 Year Retention
Scan to patient chart

CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

I give consent for my child, ____, to receive outpatient mental health services at Stanbro Healthcare Group. Outpatient mental health services include any or a combination of the following: evaluation, individual therapy, group therapy, family therapy, referral to psychological or neuropsychological testing, and medications. I consent to allow my child to participate in program activities directly associated with his/her mental health evaluation and treatment, and as appropriate, to involve my child's family members. I authorize Stanbro Healthcare Group to review my child's medical record for teaching purposes. I understand that all the personal information that I provide about my child and our family will remain confidential and any published data will keep the identity of my child and family confidential. I declare that I am this child's legal guardian.

Psychiatric assessment and evidence-based treatment includes a variety of methods aimed at two objectives:

1. Reducing or eliminating disturbing symptoms, and
2. Helping your child achieve greater psychological comfort, improved behavioral functioning and/or self-control and achieve better adjustment to life circumstances. Treatment generally consists of therapy and/or prescription of medications, psycho-education, and modification of health-related behaviors.

Please note: The purpose of the evaluation is not meant to be used for any type of court or forensic evaluation, nor is it meant to be a substitute for a disability determination.

No patient will be required to take medication and always have the right to either refuse and/or request to be taken off of any medication at any time.

With this consent for treatment, you acknowledge that any medication prescribed for your child will be taken *exactly* as prescribed. You should not change the amount or frequency of the medication without consulting first with your medical provider. It is important to consult with your medical provider *before* stopping any prescribed medication. You will complete all lab work that is requested by your medical provider. Because some medications may interact negatively with other drugs (e.g. other prescribed medications, over-the-counter substances, herbs, vitamins, illegal drug, etc.) you MUST inform your medical provider about any of these taken by your child. Please notify your medical provider if you think your child is pregnant.

SEPARATION, DIVORCE AND CHILD CUSTODY

A copy of your custody decree and/or divorce decree, which is an official court document signed by a judge, is required and must be attached to this consent for treatment.

MINOR CHILDREN IN THE CUSTODY OF THE OKLAHOMA DEPARTMENT OF HUMAN SERVICES (DHS)

A copy of the DHS consent for treatment, signed by the DHS case worker, and a copy of the DHS case worker's identification card, must be attached to this consent for treatment.

LEGAL GUARDIAN OR GUARDIAN AD LITEM

A copy of a court order, which is an official court document signed by a judge, is required and must be attached to this consent for treatment. The responsibilities and limits on the authority of the guardian must be stated in the court order.

DISCONTINUATION OF TREATMENT POLICY

NO SHOW POLICY: All new and follow up appointments must be cancelled at least 24 hours prior to the appointment time. Cancellation or reschedule requests on the day of the appointment are considered NO SHOW appointments.

Please be aware that Stanbro Healthcare Group may discontinue your child's treatment for any of the following reasons:

- ✓ Achievement of treatment goals.
- ✓ Failure to appear for two or more appointments within a three-month period, without at least a 24-hour notification.
- ✓ Being consistently late for appointments or consistently cancelling appointments.
- ✓ Not participating in treatment for a period of 90 consecutive days.

By signing below, you are giving consent for treatment of your child, and acknowledge that a parent or legal guardian must be present for each appoint if the patient is under the age of 18.

______________________________	______________________________	__________
Printed name of Parent/Legal Guardian	Signature	Date
______________________________	______________________________	__________
Printed Name of Patient	Signature	Date

PATIENT RIGHTS

As a patient at Stanbro Healthcare Group (SHG), you and your child have a right:

- To be treated with dignity and respect.
- To receive the most appropriate treatment regardless of age, gender, race, religion, sexual orientation, national origin or method of payment.
- To know what fees will be charged for your child's treatment in advance.
- To know the name and professional status of those persons providing your child's treatment.
- To participate in the development of a comprehensive Individual Treatment Plan (ITP) and to receive treatment according to this treatment plan.
- To be informed of any possible side effects of prescribed medication.
- To privacy and confidentiality concerning your child's treatment and her/his medical record. Information from your child's record will be released only with your written permission. However, all SHG staff involved with your child's treatment will share information with one another.
- To be free from physical, mental and sexual abuse or harassment.
- To be free from intrusive research.
- To have your concerns addressed in a timely manner, generally at the point of service, without fear of retaliation.
- To file a confidential verbal or written complaint regarding your child's treatment. An impartial investigation will be initiated within 24 hours of receipt of complaint. All complaints will be resolved within 30 days of the date of complaint. To file a complaint, you may:
    1. Start informally by contacting the Team Leader or any staff member. If your claim is not resolved in five (5) business days, you may contact;
    2. The Practice Manager at 405-341-1697, extension 105 or the Medical Director at 405-341-1697, extension 115.

As a patient at Stanbro Healthcare Group (SHG), you have a responsibility:

- To keep your appointment or notify us of any changes as early as possible.
- To collaborate in the development of your child's Individualized Treatment Plan (ITP).
- To work toward the achievement of your treatment goals.
- To be honest with staff by sharing anything that might impact upon your child's treatment.
- To obtain all necessary treatment referrals/prior authorizations from your child's primary care physician and from your health plan.
- To pay your fees on time/or discuss with staff any related financial difficulties.
- To promptly provide information regarding changes in health insurance, address, phone numbers and/or email address.
- To let staff know if you are dissatisfied in any way with your child's treatment.
- To inform staff of your desire to terminate treatment, especially if you have not achieved your treatment goals.

____________________	____________________	__________
Parent/Legal Guardian Printed Name	Parent/Legal Guardian Signature	Date

____

Patient Name

CONSENT, AUTHORIZATION AND ASSIGNMENT OF INSURANCE AGREEMENT

I, ____, on behalf of my child _____________________________________ hereby authorize Stanbro Healthcare Group to apply for benefits on my behalf for services rendered. I request that payments be made directly to Stanbro Healthcare Group. I affirm that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to any insurance company. A copy of this consent, authorization and assignment agreement may be used in place of the original. This agreement will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, *whether or not paid by my medical insurance*. I agree to assume responsibility for all charges incurred, should collection of this balance become necessary, including court costs and attorney's fees. I also understand that I will be charged a $50 Returned Check Fee for any checks returned for non-payment from my bank. Additionally, I understand that I am financially responsible for all non-appointment services, such as report preparation, telephone consultations, record requests, appointment no show and cancellation charges. Payment for services is expected at the time of your appointment. If you need to make payment arrangements or questions regarding your medical insurance coverage, please contact our Business Office at 405-341-1697 extension 112 prior to your appointment. Services are offered to you, the client. Responsibility for payment rests with you, not your insurance company. We will not accept responsibility for collecting from your insurance company.

____ _______________________________________
Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

_______________________ _______________________________________
Date Patient Name

USER ELECTRONIC MAIL AUTHORIZATION FORM FOR ELECTRONIC NOTIFICATIONS

Stanbro Healthcare Group utilizes an electronic patient notification system. This system is used to notify your of appointment date/times, appointment reminders, practice alerts (e.g. rescheduled appointments, unscheduled office closure do to severe weather, illness, etc.).

The electronic notifications are sent via text message, email, and automated voice messaging. By signing below, you are giving consent for us to text message, email you, or leave you a voice message regarding your appointments or group related messages. This system will not be used for marketing.

______________________________________ ____
Cell Number including Area Code Email Address

______________________________________ ______________________________________ _______
Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date

____
Patient Name

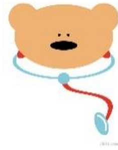
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Stanbro Healthcare Group Notice of Privacy Practices:

- It tells me how Stanbro Healthcare Group will use my health information for the purpose of my treatment, payment for treatment and Stanbro Healthcare Group health care operations.
- It explains in detail how Stanbro Healthcare Group may use and share my health information for other than treatment, payment and health care operations.
- Why Stanbro Healthcare Group will use and share my health information as required/permitted by law.

Printed Patient Name	Patient Social Security Number	Date of Birth
Printed Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian	Date

HIPAA Document
Retain for six (6) years
Scan to patient chart



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It is the policy of Stanbro Healthcare Group, in accordance with the Oklahoma State Department of Health (OSDH), to keep your medical and personal information confidential. We will only use or disclose your information for the following reasons:

- **Treatment:** We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others. We also participate in Electronic Health Information Exchange.
- **Payment:** We may use and disclose PHI when it is needed to receive payment for services provided to you. For example, if you have Medicaid benefits, we will release the minimum information necessary for the Medicaid program to pay us.
- **Health Care Operations:** We will use and disclose PJI when it is needed to make sure we are providing you with good patient care. For instance, we may review your records in order to make certain quality service was given.

Other uses or disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part of your information.
- When ordered to do so by a valid court order.
- When cases of child abuse or neglect are investigated.
- Immunization information is shared with schools and childcare centers.
- When business associates of OSDH, such as community clinics, sign agreements to protect your privacy.
- The SoonerStart Program shares information with the State Department of Education.
- When required by State law.
- We can share your information with anyone as necessary, consistent with Oklahoma law and the OSDH policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.
- When services are provided to minors, information will be shared with the Joint Oklahoma Information Network (JOIN). This is done to help us improve the services given to children. However, no one can use your child's information unless you have given permission in writing.
- In the case of a severe disaster we can disclose your information.
- We will share your PHI with other medical providers who are involved in your care to coordinate your care with others.
- We can share your information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for your care, of your location, general condition or death.

Your Rights

You have the right to:

- Receive a list of persons or organizations, other than those listed above, to whom we release your information.
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits.
- Ask that we not contact you at work.
- Inspect and copy your medical records except in cases involving certain psychotherapy notes.
- Amend incorrect information in your record.
- Revoke your written permission for release of information.
- Receive a paper copy of this Notice of Privacy Practices.

Our Responsibilities

Federal law and the OSDH and its entities require Stanbro Healthcare Group to:

- Maintain the confidentiality of your PHI.
- Provide you with a copy of this notice.
- Abide by the terms of this notice.
- Only change this notice as permitted by Federal law.
- Provide you with a way to file complaints regarding privacy issues.

For additional information regarding this notice and your rights, or to report any complaints regarding privacy issues, contact:

HIPAA Privacy Officer
Community Health Services
Oklahoma State Department of Health
1000 NE 10th Street
OKC, OK 73117-1299
405.271.5585 privacyofficer@health.ok.gov

Secretary of Health and Human Services
The US Department of Health and Human Services
Office of Civil Rights
1301 Young Street, STE 1169
Dallas, TX 75202
214.767.4056 TDD214.767.8940