STANBRO HEALTHCARE GROUP LLC

Thank you for choosing Stanbro Healthcare Group!

Our detailed intake process is designed to improve efficiency and provide the best service possible. In order to set up your appointment, we ask that you carefully fill out all 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, you will be contacted by one of our placement team members as soon as an appointment date becomes available.

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

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

Sincerely,

The SHG Team

NEW PATIENT CHECKLIST

WE ARE UNABLE TO SCHEDULE YOUR APPOINTMENT UNTIL ALL DOCUMENTATION IS COMPLETE AND RECEIVED

- ☐ **COPY OF FRONT AND BACK OF INSURANCE CARD (WE DO NOT ACCEPT MEDICARE)**
- ☐ **SIGNATURES/ DATES**
  Pages 12-17 require signatures and dates.
- ☐ **MOST RECENT PSYCHIATRIC RECORDS**
  The release of information on page 10 must be completed if you are unable to produce these records.
- ☐ **LEGAL GUARDIANSHIP DOCUMENTS**
  If applicable.
- ☐ **COPY OF PHOTO ID**
- ☐ **SCREENING TOOLS**
  Pages 10-11
- ☐ **CONTROLLED SUBSTANCE AGREEMENT**

STANBRO HEALTHCARE GROUP LLC

INFORMATION YOU 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**. We do accept Medicaid/Soonercare.

Please note that mental health coverage is frequently quite 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 you are covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your 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 _____

Address (**No PO Boxes allowed – must be a physical address**) _____

Home Telephone _____ Cell Number _____

Email Address (required) _____

Preferred Pharmacy _____

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

□ Behavior Problems
□ Anxiety
□ Obsessive Compulsive Disorder
□ Homicidal Ideation
□ Bipolar Disorder
□ Attention Deficit/Hyperactivity Disorder
□ PTSD
□ Oppositional Defiant Disorder
□ Visual Hallucinations
□ Substance Use/Abuse
□ Depression
□ PANDAS/PANS
□ Suicidal Ideation
□ Audible Hallucinations
□ Other

WHO REFERRED YOU TO STANBRO HEALTHCARE GROUP? _____

INSURANCE INFORMATION (WE DO NOT ACCEPT MEDICARE)

Primary Insurance Company: _____ Telephone Number _____
Policy/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 _____
Policy/Identification Number: _____
Group Name: _____ Group Number: _____
Subscriber's/Policy Holder's Name: _____
Subscriber's/Policy Holder's Date of Birth: _____ Social Security Number: _____

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: _____

CHILD'S HISTORY QUESTIONNAIRE

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 _____

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

□ Yes (please list below) □ No

_____

_____

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

_____

_____

_____

_____

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 people 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)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

Mood Stabilizers	**Dates**	**Dosage**	**Response/Side-Effects**
Tegretol (carbamazepine)			
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
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Vyvanse (lisdexamfetamine)			
Intuniv (guanfacine, er)			
Kapvay (clonidine, er)			
Strattera (atomoxetine)			
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 your 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 many 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 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? _____

PERSONAL AND FAMILY MEDICAL HISTORY

Thyroid Disease	□ You	□ Family	Family Member: _____
Anemia	□ You	□ Family	Family Member: _____
Liver Disease	□ You	□ Family	Family Member: _____
Chronic Fatigue	□ You	□ Family	Family Member: _____
Kidney Disease	□ You	□ Family	Family Member: _____
Diabetes	□ You	□ Family	Family Member: _____
Asthma/Respiratory	□ You	□ Family	Family Member: _____
Stomach/Intestinal	□ You	□ Family	Family Member: _____
Cancer (type) _____	□ You	□ Family	Family Member: _____
Fibromyalgia	□ You	□ Family	Family Member: _____
Heart Disease	□ You	□ Family	Family Member: _____
Epilepsy/Seizures	□ You	□ Family	Family Member: _____
Chronic Pain	□ You	□ Family	Family Member: _____
High Cholesterol	□ You	□ Family	Family Member: _____
High Blood Pressure	□ You	□ Family	Family Member: _____
Head Trauma	□ You	□ Family	Family Member: _____
Liver Problems	□ You	□ Family	Family Member: _____
Other	□ You	□ Family	Family Member: _____

Is there any additional personal or family medical history? □ No □ Yes

If yes, please explain: _____

Current Weight: _____ Current Height: _____

PAST PSYCHIATRIC HISTORY

Outpatient treatment? □ No □ Yes If yes, please describe when, by whom, and nature of treatment:

REASON	DATES TREATED	BY WHOM

Psychiatric Hospitalization? □ No □ Yes If yes, please describe for what reason, when and where.

REASON	DATE HOSPITALIZED	WHERE

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: I	Not At All 0	Just A Little 1	Quite A Bit 2	Very Muc 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 Littl 1	Quite A Bit 2	Very Muc 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) _____

STANBRO HEALTHCARE GROUP LLC

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE OR REQUEST) OF PROTECTED HEALTH INFORMATION

I authorize Stanbro Healthcare Group to use and disclose or request health information. This information specified below may be ☐ released to or ☐ requested from:

Name/Agency _____ Reason for Disclosure _____

Address, City, State, Zip _____

Telephone Number _____ Fax Number _____

The following information:

INFORMATION	DATES OF SERVICE	INFORMATION	DATES OF SERVICE
☐ Psychiatric Records		☐ Psychosocial Assessment	
☐ Laboratory Reports		☐ EKG	
☐ Entire Health Record		☐ History and Physical	
☐ Progress Notes		☐ Psychological/Educational Assessments	
☐ Current Medications		☐ Discharge Summary	
☐ Verbal Communication		☐ Other (specify)	

I also understand that my insurer requires information regarding my 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 the consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse, mental health treatment and other sensitive information. 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 Records Request Fee of 50 cents per page, payable prior to the release of the requested records. Your health insurance coverage will not reimburse you for this charge.

Printed Name of Patient _____ Date of Birth _____ Date/Time _____ (expires after 1 year)

Parent/Guardian Signature / Patient Signature _____ Date/Time _____ (expires after 1 year)

STANBRO HEALTHCARE GROUP LLC

CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

I seek to receive outpatient mental health services at Stanbro Healthcare Group. Outpatient services may be provided in office or by telepsychiatry. Outpatient mental health services include any or a combination of the following: evaluation, supportive therapy, referral to psychological or neuropsychological testing, and medications. Telepsychiatry is an extension of patient care that allows patients to access psychiatric care using audio-video interface videoconferencing. Electronic videoconferencing systems used will incorporate network and software security protocols including but not limited to encrypted data transmission of video conference, password protected screen savers and privacy protected virtual waiting rooms to protect the confidentiality of patient identification and imaging data. This will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry, which identifies me, will be disclosed to researchers or other entities without my consent. I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I agree to take full responsibility for the security of any communications or treatment on my own device and in my own physical location. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I consent to participate in program activities directly associated with my mental health evaluation and treatment, and as appropriate, to involve my family members. I authorize Stanbro Healthcare Group to review my medical record for teaching purposes. I understand that all the personal information that I provide about myself and my family will remain confidential and any published data will keep my identity and my family's identity confidential.

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

1. Reducing or eliminating disturbing symptoms, and
2. Helping you or your child achieve greater psychological comfort, improved behavioral functioning and/or self-control and achieve better adjustment to life circumstances. Treatment generally consists of supportive 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 you or 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 currently being taken. **Please notify your medical provider if you think you are pregnant**.

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 treatment for any of the following reasons:

- ✓ Noncompliance of treatment goals.
- ✓ Failure to appear for two or more appointments within a twelve-month period, without at least a 24-hour notification.
- ✓ Being consistently late for appointments or consistently cancelling appointments.
- ✓ Being disrespectful to staff and/or disrupting the care of other patients. Inappropriate behavior will not be tolerated.

By signing below, you are giving consent for treatment.

Printed Name of Patient	Parent Signature	Date

STANBRO HEALTHCARE GROUP LLC

PATIENT RIGHTS

As a patient at Stanbro Healthcare Group (SHG), you 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 treatment in advance.
- To know the name and professional status of those persons providing your 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 treatment and medical record. Information from your record will be released only with your written permission. However, all SHG staff involved with your 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 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 any staff member. If your claim is not resolved in five (5) business days, you may contact the Practice Manager at 405-341-1697.

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 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 treatment.
- To obtain all necessary treatment referrals/prior authorizations from your 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 treatment.
- To inform staff of your desire to terminate treatment, especially if you have not achieved your treatment goals.

Printed Name of Patient	Parent Signature	Date

STANBRO HEALTHCARE GROUP LLC

CONSENT, AUTHORIZATION AND ASSIGNMENT OF INSURANCE AGREEMENT

I, _____, 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 it is 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 have questions regarding your medical insurance coverage, please contact our Business Office at 405-341-1697 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 Patient	Parent Signature	Date

USER ELECTRONIC MAIL AUTHORIZATION FORM FOR ELECTRONIC NOTIFICATIONS

Stanbro Healthcare Group utilizes an electronic patient notification system. This system is used to notify you 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.

Printed Name of Patient	Parent Signature	Date

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 Name of Patient	Parent Signature	Date

STANBRO HEALTHCARE GROUP LLC

Controlled Substances Agreement

I, _____, understand and voluntarily agree that
(initial each statement after reviewing)

_____ I will keep and be on time for all my scheduled appointments with Stanbro Healthcare Group. Cancellations and/or no showing my scheduled appointments may result in denial of my prescription until I am seen by my provider.

_____ I understand that some controlled substances are not intended to be taken long term and my provider may taper and discontinue my controlled substance at any time.

_____ If at any time I am prescribed a narcotic by an outside provider, I will immediately contact my provider with Stanbro Healthcare Group. Concurrent use of a narcotic and a benzodiazepine will result in an immediate taper of my controlled substance (i.e. Ativan, Xanax, Valium, Klonopin).

_____ I am responsible for the controlled substance medications (i.e. Adderall, Xanax, Ambien) prescribed to me. If my prescriptions are lost, stolen, or if "I run out early", I understand this medication will not be replaced regardless of the circumstances.

_____ I may be asked to complete random urine testing.

_____ I understand my refill request may take up to 72 hours to process if requested outside of my scheduled office visit. It is my responsibility to schedule follow-up appointments for refills.

_____ I will treat the staff at the office respectfully at all times. Being disrespectful to staff or disrupting the care of other patients will not be tolerated.

_____ I understand that if I violate any of the above conditions, my treatment which includes prescriptions for controlled medications, may be terminated and I will be subject to dismissal from Stanbro Healthcare Group.

Patient Name (please print)	Patient Signature	Date
Parent Name/Guardian (please print)	Signature of Parent/Guardian	Date

STANBRO HEALTHCARE GROUP LLC

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left your provider. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.**

☐ **You may contact me by telephone**	**Telephone Number:**
☐ **You may leave a message/voicemail**	**Email Address:**
☐ **You may contact me by email**	
☐ **You may contact me by mail**	

Name/Phone Number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
3.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
4.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
5.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient

STANBRO HEALTHCARE GROUP LLC

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 PHI 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 being 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