Welcome to

Sun Valley Behavioral Medical Center, Inc.

Please give us the following information, in order to help us expedite your services

Name _____ Date of Birth _____ Age _____

Sex: Male / Female SSN _____ Occupation _____

Marital Status: Single Married Divorced Separated Widowed Spouse Name _____

Mailing Address _____

City, State, Zip code _____ Phone Number (_____) _____

Email address _____

Emergency contact & phone # _____

If patient is a minor, Parent/Guardian Name _____

*Minor has to be accompanied by a person 18 years of age or older

*For Divorced Parents: Who has custody _____

Insurance Company Name _____

Policy Holder's Name _____ Policy Holder's DOB _____

Policy Holder's SSN _____ Relationship to patient _____

Office Policy

1. All information is kept in the strictest confidence. However, we do send acknowledgement to referring physicians, therapists, or agencies. We are also required by law to report incidents/suspicion of child/elderly abuse or threats to self and others.

2. Due to confidentiality, it is the patient's responsibility to directly schedule appointments, make appointment changes, request prescriptions, or phone inquiries.

3. The preferred form of contact is our office phone number. If your physician/therapist is not available you may leave a message with staff or on our confidential voicemail. If you wish your physician/therapist to return your call, please be sure to leave your name and phone number(s) along with a brief message concerning the nature of your call. Even if you consider your call to be urgent or highly important, please **do not attempt to contact your physician/therapist by other means than the official Sun Valley Behavioral phone number (i.e. personal phone, cell phones, and emails, as well as other form of electronic/web-based form of communication).**

4. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or contact local law enforcement. The local hotline can provide with support and brief intervention if needed, their services are available 24/7. The local hotline phone number is 760-352-SURE (7873).

5. In an effort to reduce medical errors and improve patient safety, your picture will be taken as part of our identification process also called "positive patient identifier."

6. Sun Valley Behavioral Medical Center has agreements with various academic centers, so during your visit, you may be seeing different healthcare professionals (i.e., physician, nurse practitioner, nurse, psychotherapist, or counselor), who may be temporarily rotating through our clinic. These professionals may be at various levels of training (i.e., resident, intern, student), and will assist in your care. Their goal is to improve the quality of your care.

Patient Financial Responsibility Agreement

We at Sun Valley Behavioral Medical Center, Inc. (SVBMCI) are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles and Co-Payments: If you have not met your health plan's deductible on the date of service, we will collect and estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: It is your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: If your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Returned Checks: We charge a $35.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before you are to be seen in our office. Failure to cancel an appointment in a timely manner will result in a No Show fee of $50.00. Multiple No Shows (3 maximum) will result in the patient being discharged from our office.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

Contact: If you have any questions regarding your bill, please contact Mendez Billing Services at 760-355-8817.

I have read the above financial policies of SVBMCI as well as the office policy and agree to be bound by its terms. I also understand that SVBMCI has the right to amend these policies at any time.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____ Relationship to Patient: _____

Contact Phone Number of Responsible Party: _____

PARENT OF CHILD OR ADOLESCENT, PLEASE ANSWER THESE QUESTIONS:

Describe the behaviors of your child that are of concern to you:

_____

Name of male parent/guardian _____ Age _____ Ph _____

Name of female parent/guardian _____ Age _____ Ph _____

School child is presently attending _____ Grade _____ Teacher _____

Has your child ever been recommended to be retained in grade? YES NO

Who is your child's Doctor? _____ Is your child taking medication? YES NO

Please list: _____

Does your child have any allergies? YES NO Please list: _____

Has your child ever had dizzy spells, convulsions, head injuries or unconscious periods? YES NO

Does your child have any physical disabilities or other limitations? YES NO

Accidents or hospitalizations:

_____ Age _____

_____ Age _____

How old was the mother at the time of this child's birth? _____

Were there problems during pregnancy/delivery? YES NO Were there problems during the first 6 months of life? YES NO

List age at what child: Walked alone _____ Spoke his/her first word _____ Was weaned off the bottle _____

Was bowel trained _____ Rode bicycle without training wheels _____

Where was the child born? _____

How long has child been in the Valley? _____ Is this child adopted or a foster child? YES NO

With whom has child lived most of his/her life? _____

If parents are divorced or separated, about how old was the child at the time? _____

List persons living in the home with child:

NAME	RELATIONSHIP	AGE

FATHER OR ADULT MALE:

What relationship to the child is the adult male in the family? (i.e. father, uncle, stepfather) _____

Is father still living? YES NO Is he currently employed? YES NO How many years of education does the adult male have? _____

MOTHER OR ADULT FEMALE:

What relationship to the child is the adult female in the family? (i.e. mother, aunt, stepmother) _____

Is mother still living? YES NO Is she currently employed? YES NO How many years of education does the adult female have? _____

Has there ever been a period of a week or longer with changes in (circle all that apply):

Sleeping habits Eating habits Level of activity Energy level Body weight Mood, i.e. euphoria, depression, anger

Memory Rate of speech

Have there ever been suicide statements, thoughts or attempts? YES NO

Has ever been use of any of the following? (Circle all that apply)

Alcohol Tobacco Marihuana Crystal/cocaine Acid/LSD Downers Heroin

Is there drinking, drug abuse, depression or suicide in the family? YES NO

Do you have any specific questions for me? _____

Pediatric Symptom Checklist-35 Youth Report Name_____ Today's date_____

Sintomas de Pediatra-35 Informe del Joven Nombre_____ Fecha de hoy_____

Mark under the heading that best describes you ***Indique cual sintoma mejor te describe:***	Never Nunca 0	Sometimes A Veces 1	Often Seguido 2
Complain of aches and pains ***Sientes dolores y malestares***			
Spend more time alone ***Pasas mucho tiempo solo(a)***			
Tire easily, little energy ***Te cansas facilmente, poca energia***			
◆ Fidgety, can't sit still ◆ ***Eres inquieto(a)***			
Have trouble with the teacher ***Tienes problemas con los maestros***			
Less interested in school ***Estas menos interesado(a) en la escuela***			
◆ Act as if driven by a motor, overly energetic ◆ ***Eres incansable***			
◆ Daydream too much ◆ ***Eres muy sonador(a)***			
◆ Distract easily ◆ ***Te distraes facilmente***			
Feel afraid of new situations ***Te sientes temoroso(a) en nuevas situaciones***			
✱ Feel sad, unhappy ✱ ***Te sientes triste, infeliz***			
Are irritable, angry ***Eres irritable, te enojas mucho***			
✱ Feel hopeless ✱ ***Te sientes sin esperanzas***			
◆ Have trouble concentrating ◆ ***Tienes problemas para concentrarte***			
Less interested in friends ***Te sientes menos interesado(a) en tus amistades***			
▣ Fight with other kids ▣ ***Te peleas con otros ninos(as)***			
Absent from school ***Te ausentas de las escuela***			
School grades dropping ***Las notas escolares estan bajando***			
✱ Down on yourself ✱ ***Te criticas a ti mismo(a)***			

Mark under the heading that best describes you ***Indique cual síntoma mejor te describe***	Never Nunca 0	Sometimes A Veces 1	Often Seguido 2
Doctor visits and doctor finding nothing wrong ***Consultas al doctor y no te encuentra nada malo***			
Have trouble sleeping ***Tienes problemas para dormir***			
✱ Worry a lot ✱ ***Te preocupas mucho***			
Want to be with parent more than before ***Quieres estar con tus padres mas que antes***			
Feel that you are bad ***Te sientes malo(a)***			
Take unnecessary risks ***Tomas riezgos innecesarios***			
Frequent injuries ***Te lastimas frequentemente***			
✱ Seem to be having less fun ✱ ***Parace que te diviertes menos***			
Act younger than children your age ***Actuas mas chico que los ninos de to propia edad***			
▣ Do not listen to rules ▣ ***No obedeces reglas***			
Do not show feelings **No demuestras tus sentimientos**			
▣ Do not understand other's feelings ▣ ***No comprendes los sentimientos de otros***			
▣ Tease others ▣ ***Se burla de otros***			
Blame others for your problems ***Culpas a otros por tus problemas***			
▣ Take things that do not belong to you ▣ ***Tomas cosas que no te pertenecen***			
▣ Refuse to share ▣ ***Te rehusas a compartir***			

Total ◆_____Total ▣_____Total ✱_____ ◆+▣+✱_____ Grand Total _____

Does your child have any emotional or behavioral problems for which you want help?
Tiene algun problema emocional o de comportamiento por el cual quiere ayuda?
No ○ *Yes/**Si*** ○

Is your child currently seeing a mental health counselor?
Por el momento se estas consultando con un profecional de salud mental ?
No ○ *Yes/**Si*** ○

www.sunvalleyb.com

CONSENT TO USE INFORMATION FOR RESEARCH PURPOSES

At Sun Valley Behavioral Medical Center, we conduct research projects in order to better understand psychiatric and behavioral disorders, and improve the care we provide. We do this by presenting our research results in scientific forums.

This is based on the use of clinical information registered in your chart. If we decide to extract any information from your chart, we assure that confidentiality of your identity will be preserved, based on HIPAA regulations.

You may refuse to give consent or withdraw your consent to use your information at any time; without jeopardizing or interfering with the treatment you receive.

- ☐ I give consent to use information for research purposes.
- ☐ I do not give consent to use information for research purposes.

Name_____ (if under age 18, a parent/tutor should sign)

Signature_____ Date_____

CONSENT TO BE PHOTOGRAPHED OR VIDEOTAPED FOR RESEARCH OR TEACHING PURPOSES

At Sun Valley Behavioral Medical Center, we conduct research projects in order to better understand psychiatric and behavioral disorders, and improve the care we provide. We do this by presenting our research results in scientific forums.

We request your consent in case we find it necessary and useful to videotape or photograph any clinical manifestation of your illness. We assure you that this material will be used in accordance to HIPAA regulations in order to protect your confidentiality.

You may refuse to give consent or withdraw your consent to be photographed or videotaped; without jeopardizing or interfering with the treatment you receive.

- ☐ I give consent to be photographed or videotaped.
- ☐ I do not give consent to be photographed or videotaped.

Name_____ (if under age 18, a parent/tutor should sign)

Signature_____ Date_____