FUSION
Behavioral Health & Fitness

Client Last Name:_____

CLIENT INTAKE DATA: PLEASE COMPLETE ALL PAGES

Child's Name (First, Middle, Last): _____

Age: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Transgender (PP:_____)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Ok to send mail? ☐ Yes ☐ No: If no, please provide alternative address:

_____

Parent/Guardian Information:

Name: _____ Relationship: _____

Occupation: _____ Email: _____

Home phone: _____ Ok to leave a message: ☐ Yes ☐ No

Cell phone: _____ Ok to leave a message: ☐ Yes ☐ No

Name: _____ Relationship: _____

Occupation: _____ Email: _____

Home phone: _____ Ok to leave a message: ☐ Yes ☐ No

Cell phone: _____ Ok to leave a message: ☐ Yes ☐ No

Parents' Relationship Status:

☐ Married ☐ Divorced ☐ Never Married ☐ Separated

☐ Remarried ☐ Domestic Partnership ☐ Single ☐ Widow(er)

Custody Arrangement (if applicable): _____

Is your child adopted? ☐ Yes ☐ No

If yes, at what age? _____ Been informed? ☐ Yes ☐ No ☐ N/A

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Name(s) and age(s) of sibling(s): _____

_____

Name(s) and relationships of others living in the home: _____

_____

Name(s) of other significant people in child's life: _____

_____

Referral Source (How did you hear about us?):

_____

MEDICAL HISTORY

Significant medical history relating to birth, infancy, and childhood: _____

_____

_____

_____

Were developmental milestones met in an expected timeframe? _____

_____

Is your child currently under the care of a doctor or other medical health professional? ☐ YES ☐ NO

Primary Care Physician: _____

Primary Care Physician Phone Number: _____

Please list any medications your child is currently taking:_____

_____

Do you notice a difference in your child when s/he is taking medication? ☐ YES ☐ NO

Has your child been medically cleared to engage in physically exercise?: ☐ YES ☐ NO

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Mental Health History

Has your child received a formal mental health diagnosis? If so, please list and provide the name of professional:

_____

_____

What are the reasons that have brought you to Fusion?

_____

_____

_____

How long have these symptoms been a concern to you?

_____

Have you sought professional help for your child in the past? If so, what did you find to be helpful and what did not work for you at the time?

_____

_____

_____

Has your child ever thought of hurting themselves or others?	☐ Yes	☐ No	☐ Unsure
Has your child ever made a plan to hurt themselves or others?	☐ Yes	☐ No	☐ Unsure
Has your child ever purposefully hurt themselves or others?	☐ Yes	☐ No	☐ Unsure

Is there a history of mental illness in child's family (immediate and extended)? If so, please list:

_____

Describe your child's ability to manage frustration. What is helpful and what increases the level of frustration?: _____

_____

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How does your child manage transitions? _____

_____

Does your child follow the rules? What occurs when/if they do not comply? _____

_____

Describe your relationship with your child: _____

_____

_____

Education Information

Current School Attending: _____

Grade: _____ Dismissal Time: _____

How would you describe your child's academic performance? _____

_____

Does your child receive any special education services (IEP/504); if so, what for?_____

_____

Legal Information

Is your child currently involved in any legal proceedings? ☐ Yes ☐ No

If yes, please describe: _____

_____

Trauma History

Does your child have a history of experiencing a trauma? If yes, please describe: _____

_____

_____

Social Information

How would you describe your child's ability to manage social interactions? _____

_____

_____

Does your child understand how to read and respond to social cues? _____

_____

Does your child have a core group of friends? What do they enjoy doing together? _____

_____

What are your child's greatest areas of success?_____

_____

_____

What are your child's greatest areas of struggle? _____

_____

_____

What are your child's hobbies and extracurricular activities? _____

_____

_____

Please list, in order of preference, what areas of treatment you would like the clinical staff at Fusion Behavioral Health & Fitness to focus on when working with your child:

1. _____
2. _____
3. _____

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PHYSICAL EXERCISE INFORMATION

Are you aware that some of the therapeutic interventions used at Fusion involve physical exercise?

☐ YES ☐ NO

Please describe your child's level of comfort engaging in physical exercise:

_____

_____

What is your child's current activity level? _____

Do you feel that your child experience any barriers to a physical exercise routine?

_____

_____

_____

Are there any medical conditions or injuries that might prevent your child from exercising?

☐ YES ☐ NO If yes, please list: _____

_____

By signing below, you are acknowledging that your child may be asked to engage in physical activity as a therapeutic intervention for their treatment. It is your responsibility to verbalize to Fusion staff if you or your child are not comfortable with this intervention or if medical concerns arise. At no time will staff force a client to engage in physical exercise against their will.

_____ _____

Signature Date Printed Name

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Client Last Name:_____

CLIENT AGREEMENT

Confidentiality: Please see and complete informed consent form with your clinician; copy can be provided to client.

Scheduling and Fees: Sessions will be scheduled with your clinician. Session-length is determined by your insurance carrier and will be discussed during intake with your clinician. Typically, family sessions will be scheduled for 50-60 minutes and individual sessions will be scheduled for 40-50 minutes. Scheduled sessions will begin promptly at the agreed upon time; if you are unable to arrive on time, sessions will still end at the expected time.

Fusion requires 24 hour notice for cancellation of session time; if session is not cancelled within 24 hours, a cancellation fee of $50 will be charged to your account. Health insurance providers cannot be billed for these cancellations.

Initial evaluation: $125 per intake
Individual and Family Therapy: $120 per session
Documentation Fee for Letters, Reports & Review: $80 per hour

Insurance Benefits: Fusion BHF is contracted with several private insurance agencies. If Fusion is contracted with your health insurance provider, they will be billed according your contract. If Fusion is not contracted with your insurer, you are expected to pay for services at the time of your visit and you are responsible for seeking reimbursement from your insurer. Please note that you are responsible for payment of services and comprehensive understanding of your individual insurance contract (including deductibles and copayments.)

Name of Subscriber:_____ DOB:_____

Address:_____

Insurance Company: _____

Policy Number: _____

Emergency Coverage: Fusion BHF is not a crisis provider; while we work hard to respond promptly, our clinicians are not readily available in emergency situations. Should a clinical emergency arise, it is your responsibility to seek appropriate medical care at your local emergency room or by calling 911.

Inclement Weather Policy: Fusion BHF will consider with the greatest safety concerns if closure is necessary due to inclement weather. If Fusion requires closure, a message will be left on our answering machine, our website will update with a message, and our social media sites will be updated as well.

Agreement: I have read the above and agree to participate in treatment according to Fusion Behavioral Health & Fitness policies.

_____ _____

Signature Date Printed Name

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Client Last Name:_____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Client Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

I authorize Fusion Behavioral Health & Fitness to leave messages with medical information on:

☐ Home Phone ☐ Cell Phone

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to the Fusion Behavioral Health & Fitness office. My revocation will be effective once received by Fusion Behavioral Health & Fitness staff.
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
3. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

_____ _____

Signature Date Printed Name

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CREDIT CARD AUTHORIZATION FORM

Fusion Behavioral Health & Fitness requires all clients to keep a credit card on file. You may choose to pay session fees at the time of your appointment with another method of payment but you must inform your clinician at the time of session. Otherwise, session fees, copayments, cancellation fees, etc. will be charged to the card submitted below.

Cardholder Name: _____

Client Name on File: _____

I hereby authorize Fusion Behavioral Health & Fitness to charge current and future fees for services received by myself, my child, or my family. I understand that if my account has an outstanding balance, it will be charged.

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Is this an HSA/FSA card? ☐ Yes ☐ No

Card Number: _____

Expiration Date: _____ CSV Code: _____

Name on Card: _____

Cardholder Signature: _____

Address if different than client: _____

_____

This credit card authorization will be valid through December 31, 20__ at which this form will be destroyed according to strict security standards.

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CONSENT FOR RELEASE OF INFORMATION

Consent forms should only be completed if you have requested your Fusion Behavioral Health & Fitness clinician make contact or receive contact from a formal service provider, family member, or other on your behalf.

Client Name: _____ DOB:_____

I, _____ as a client, parent or legal guardian, hereby authorize **FUSION BEHAVIORAL HEALTH AND FITNESS** clinical staff to request and obtain information from:

_____

_____

_____

Information to be released:

- ☐ Evaluations
- ☐ Treatment Plans
- ☐ Medical Records
- ☐ Progress Notes
- ☐ Developmental/Sensory History
- ☐ Feedback on Progress Made in Treatment
- ☐ School Records
- ☐ Other: _____

I acknowledge that this consent is voluntary and is valid for one year. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already been taken.

_____ _____

Signature Date Printed Name

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