CHILD

CORSICA RIVER MENTAL HEALTH SERVICES, INC.

120 BANJO LANE
CENTREVILLE, MD 21617
Phone - (410) 758-2211
Fax - (410) 758-0698

933 S. TALBOT STREET
ST. MICHAELS, MD 21663
Phone - (410) 745-8028
Fax - (410) 745-0492

502 POPLAR STREET
CAMBRIDGE, MD 21613
Phone - (443) 225-5780
Fax - (443) 225-5783

Thank you for your interest in Corsica River Mental Health Services, Inc. The enclosed packet contains the items you will need to complete prior to coming into the clinic for open enrollment for services. Along with the enclosed packet of information, we also need you to bring the following documentation:

- ☐ All current Insurance Cards - primary and secondary*
- ☐ Photo ID
- ☐ Patient Social Security Card
- ☐ Primary Medical Doctors name, address and phone number
- ☐ Proof of custody (Custody order), if applicable
- ☐ Immunization record
- ☐ Birth Certificate
- ☐ List of all Medications

It is requested you bring the following, if applicable:

- ☐ Reports from previous psychological evaluations/testing
- ☐ Copies of child's Individualized Education Plan (IEP)

* If you/your child currently has no insurance, please bring in the following for income verification:

- ☐ 3 most current pay stubs

OR

- ☐ Prior Year tax return

REGISTRATION FOR SERVICES DAYS AND TIMES:

(Children's attendance at the registration meeting is not required.)

Please check the website or call any of the above numbers for clinic hours.

Acceptance and schedule for Intake is dependent on qualifying for services and, if required, obtaining authorizations for services.

Failure to provide all necessary documents can result in no scheduled clinical visits.

****** Please be advised: There is a Wait List for ALL Private insurance. In order to be added to the list, Registration process must be completed. ******

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IMPORTANT POLICY INFORMATION AFFECTING CLIENTS

MEDICATION REFILL POLICY:

Please allow 7 days to complete any refill requests. If you wait until you are our of medication, we cannot guarantee that we can complete your request on time.

PRESCRIPTION POLICY:

It is policy of CRMHS to not prescribe any Schedule II Controlled Substances. This includes the following medications:

Klonipin / Clonazepam
Ativan / Lorazepam
Diazepam / Valium
Alprazolan / Xanax

CLINICAL OPINION POLICY

CRMHS will not render clinical opinion on any matter related to competence, custody and/or visitation, quardianship, parental rights or any other legal matter which involves making a judgement that is based on information that cannot be obtained in the process of the traditional therapeutic relationship. CRMHS will not write any letters of support in this area.

RELEASE OF INFORMATION/ACCESS TO MENTAL HEALTH RECORD:

CRMHS will treat all requests for access and/or release of information records and information to clients and/or parent/guardians of a client in the same manner. An appropriate and documented release of information must be in the file for any outside agency and/or person requesting records, appointment verification, etc.

NON-PAYMENT POLICY

All clients are expected to pay their share of the cost of service at the time service is rendered, for example; co-payments/deductibles/co-insurance or self pay clients. Any client that has a unpaid balance of more than $100, must pay their co-pay plus 10% of the balance owed at each visit until balance is paid in full. CRMHS administrative office reserves the right to reschedule appointments if clients are not able to pay at time of service. CRMHS will assist clients in accessing any applicable entitlements that can reduce or eliminate the financial burden of service.

Corsica River Mental Health Services, Inc.
Client Information / Referral Form
PLEASE PRINT CLEARLY

Date: ____________________

Client's Name: ____________________

Address: ____________________

City: __________ State: ______ Zip: ________ County: __________

Phone#: (home) __________ (work) __________ (cell) __________

Social Security #: __________ Date of Birth: __________

Age: ____ Race: ________ Marital Status: __________ Gender: ☐ Male ☐ Female

Primary Care Physician: ____________________ Phone#: __________

Address: ____________________

Date last seen: ________ Immunizations Current (for minors): ☐ Yes ☐ No If no, please explain: ___

____

Allergies: ____________________

Employed: ☐ Full Time ☐ Part Time ☐ Not Employed

Employer: ____________________

Address: ____________________ Phone: __________

Spouses Employer (if applicable): ____________________

Address: ____________________ Phone: __________

Insurance Provider: __________ Policy #: __________ Group #: __________

Policy Holder's Name: ____________________

Address (if different from above): ____________________

City: __________ State: ______ Zip: ________ County: __________

Phone#: (home): __________ (work) __________ (cell) __________

Social Security # __________ Date of Birth: __________

Secondary Insurance Provider: __________ Policy # __________ Group #: __________

Policy Holder's Name: ____________________

Address (if different from above): ____________________

City: __________ State: ______ Zip: ________ County: __________

Phone#: (home): __________ (work) __________ (cell) __________

Social Security # __________ Date of Birth: __________

Primary Emergency Contact

Name: __________ Address: ____________________

Phone #: (home/cell) __________ (work) __________ Relationship: __________

See Reverse Side

Client Name ____________

Two Additional Emergency Contacts (required if the client in a minor)

Name: ____________ Address: ____________

Phone #: (home/cell) ____________ (work) ____________ Relationship: ____________

Name: ____________ Address: ____________

Phone #: (home/cell) ____________ (work) ____________ Relationship: ____________

Referral Information

Person/Agency Referring: ____________ Relationship: ____________

Contact Info: Phone #: ____________ Fax: ____________ Email: ____________

Reason for Referral ____________

Prior mental health treatment (include names, dates of psychiatric hospitalizations): ____________

Current Medications: ____________

Substance Abuse History: ____________

Legal Issues / Guardianship/ Court Orders / Probation: ____________

Suicidal / Homicidal / Paranoid Ideations / Hallucinations: ____________

Are you a Veteran? ____ Yes ____ No Did you serve in Iraq and/or Afghanistan conflicts? ___ Yes ___ No

If client is a minor please complete the Child Adolescent Questionnaire.

Corsica River Mental Health Services, Inc.
Child/Adolescent Referral Questionnaire
PLEASE PRINT CLEARLY

Date: ____________

Form completed by:
Name: ______________________ Relationship to client: ____________

Address (if different from child's): ______________________

City: ____________ State: ______ Zip: ________ County: ____________

Phone#: (home): ____________ (work) ____________ (cell) ____________

Child's Name: ______________________ Date of Birth: ____________

A. Please give YOUR reason for bringing this child to Corsica River Mental Health Services and what you would like to happen as a result: ______________________

____

____

____

B. FAMILY INFORMATION:

1. Marital status of birth/adoptive parents: ______ never married ______ married
   ______ divorced ______ separated
2. Who does the child live with? ______________________
3. Their relationship to the child? ______________________
4. Does the person(s) or entity listed above have legal custody of the child? ____________
5. Does the person or entity other than the custodian have Guardianship? ____________

   If so, Who? Name: ______________________

   Address: ______________________

   City: ____________ State: ______ Zip: ________ County: ____________

   Phone#: (home): ____________ (work) ____________ (cell) ____________
6. If there is a non-custodial parent is he/she involved with this child? ____________
7. Does that person pay child support? ______________________
8. Does your child relate well to brother(s) or sister(s)? ______________________
9. Does this child relate well to his/her parents or guardians? ______________________

C. MENTAL/EMOTIONAL HISTORY

1. Has your child ever been in therapy, counseling, or a psychiatric hospital? ____________

   If so, Where? ______________________
2. Has your child had any psychological or psycho-educational evaluations? ____________

   If so, Where? ______________________
3. Has your child ever attempted suicide in the past? ______________________

   If so, What were the circumstances? ______________________

Name: ____________________
DOB: ____________________

D. MEDICAL HISTORY

1. Did you have a problem pregnancy with this child? ____________________
2. Has he/she had any severe illnesses, operations, or hospitalizations? ____________________
   If so, What? ____________________
3. Are you concerned about any areas of your child's development? ____________________
   If yes, please explain: ____________________
   ____
4. Please list his/her current:

Medical Conditions	Medications	Dosage / Frequency

5. How would you describe your child's physical health overall?
   ______ Very Good ______ Good ______ Fair ______ Poor

E. SCHOOL HISTORY

1. The school / daycare your child attends: ____________________
2. What grade is he/she in: ____________________
3. Has this child ever repeated a grade? ____________________
   If so, which grade? ____________________
4. During the most recent month of school, how many days was the child absent for any reason? ____________________
5. What does he/she like best in school? ____________________
6. What does he/she like least in school? ____________________
7. Does he/she have any academic problems? ____________________
8. Does he/she have any behavior problems in school? ____________________
9. Has the school ever suggested using an outside resource (tutor, counselor, etc.) for his/her problems? ____________________
10. Does he/she relate well to friends and classmates? ____________________
11. How would you describe this child's relationships to his/her teacher(s)?
    ______ Excellent ______ Good ______ Fair ______ Poor

F. DISCIPLINE

1. How has this child been disciplined? (Check all that apply)
   ____ spanking ____ restriction ____ time out ____ isolation ____ discussion
   ____ scolding ____ slapping ____ added chores ____ withdrawal of privileges ____ other
2. Have these ways of disciplining been effective? ____________________
   If not, please explain: ____________________
   ____

Name: ____________________
DOB: ____________________

3. How often do you discipline this child? ____________________

G. OTHER RELATED INFORMATION

1. What qualities does this child have that you find particularly appealing? ____________________
____
____
2. Does your child have any special talents or hobbies? ____________________
If yes, please describe: ____________________
____
3. Has your child ever been physically or sexually abused by anyone? ____________________
4. Does he/she exhibit any unusual sexual curiosity or activity? ____________________
If yes, please describe: ____________________
____
5. Does he/she have any behaviors you are concerned about (cruelty to animals, bedwetting, setting fires, etc.)? __________
If yes, please describe: ____________________
____
6. Has this child been brought to the attention of law enforcement officials or juvenile authorities? ____________________
If yes, please describe the circumstances: ____________________
____
7. To whom does this child turn when in trouble (parents, friends, classmates, etc.)? ____________________

Signature: ____
Parent/ Guardian/ DSS

Mental Health Screening Form-III(MHSF-III) Screening Instrument

Screening Date________________________

Number of days since last use of alcohol and/or other drugs__________

I am going to ask you some questions and please note the each item refers to your entire life

History, not just your current situation, this is why each question begins – "Have you ever..."

1. Have you ever talked to a psychiatrist, therapist, social worker or counselor about an emotional problem? YES______ NO______
2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help ? YES______ NO______
3. Have you ever been advised to take medication for anxiety, depression, hearing voices or for any other emotional problem? YES______ NO______
4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES______ NO______
5. Have you ever heard voices no one else could hear or seen objects or things which others could not see or hear? YES______ NO______
6. Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions or thought about killing yourself? YES______ NO______
   Did you ever attempt to kill yourself? YES______ NO______
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES______ NO______
8. Have you ever experienced any strong fears? For example of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? YES______ NO______
9. Have you ever given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? YES______ NO______
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES______ NO______
11. Have you ever experienced any emotional problems associated with your sexual interests, you sexual activities or you choice of sexual partner? YES______ NO______

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw-up? YES______ NO______

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES______ NO______

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

YES______ NO______

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying or maintaining very rigid schedule of daily activities from which you could not deviate.

YES______ NO______

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES______ NO______

17. Have you ever been told by teachers, guidance counselors or others that you have a special learning problem? YES______ NO______

SCORE:(Questions 1 and 2 are not scored)

Number of "YES" answers________

*Screened positive = a score of 1 or greater

F.X. Carroll, PHD and John J. McGinley, M.S.,M.S.W., Project Return Foundation 2000

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CONSENT FOR TREATMENT OF A MINOR

I, ______________________________________, give permission for Corsica River Mental Health
(parent/guardian's name)

Services, Inc. to provide mental health services to ______________________________________.
(minor child's name)

I am legally authorized to provide this permission based on the following:

- ☐ Parent
- ☐ Guardian
- ☐ Foster Care Provider

Attached are the following legal documents to support this claim:

- ☐ Birth Certificate
- ☐ Court Order Custody Agreement
- ☐ Power of Attorney
- ☐ Probation Order
- ☐ Health Care Passport
- ☐ Other ______________________________

I understand that the mental health treatment I am agreeing to may include Individual, Family, and/or Group Psychotherapy for my child, myself, and family. I further understand that records will be kept and that these will be held confidential as permitted by law. My child may be evaluated by a Psychiatrist for the purpose of providing diagnostic confirmation and medication assessment. If medications and/or a psychological evaluation are considered, then I understand that I will be informed of the purpose of such and of any possible risks involved.

In the case of an emergency, I authorize the staff of Corsica River Mental Health Services, Inc. to provide any and all necessary emergency medical treatment.

______________________________ ______________________
Parent/Guardian Signature Date

______________________________ ______________________
Parent/Guardian Signature Date

______________________________ ______________________
Client Signature Date

______________________________ ______________________
Witness Signature Date