

## Partnership Pledge

Thank you for choosing the Mental Health Program at Children's Hospital of the King's Daughters. Participating in care within our Mental Health Service Line involves your entire family and our team. Your child's success is important to us and is greatly dependent on everyone's commitment to respectful interactions, as well as consistent attendance, and family participation.

With your collaboration, your child's CHKD Mental Health Team will define a treatment plan that will include the kind of treatment and the frequency of visits. Effective communication is a critical part of this process and depends on respectful interactions and a safe environment. All children we see benefit from seeing adults model for them how to use respectful language and tone.

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. The consistency of attending therapy sessions assures that your child will obtain maximum treatment benefit, and assist in meeting your goals. A missed or late appointment disrupts therapy schedules that impact both you and other patients who are waiting for care.

The following guidelines help us provide safe, quality care for your child.

### **By reading and signing this form you agree to our family attendance and communication expectations.**

#### Attendance

- Arrive on time to scheduled appointments
- Parent attendance at first appointment is mandatory
- I understand that if my child attends therapy unaccompanied then a guardian needs to be available during the time of the appointment in case of an emergency.
- Attend therapy sessions as scheduled
- Cancellations **must be made 24 hours in advance**. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel 24-hours in advance and do not attend therapy, this will be considered a "no-show".
- **I understand that three no shows or cancellations are grounds for discharge from therapy.** A letter will be mailed to you informing you of discharge from the program and a community resource list for future care.
- I understand that my referring provider will be notified of my missed appointments and the resulting discharge from therapy.
- I understand that if I arrive fifteen minutes late, my therapy session may either be cancelled or shortened.
- If I am out of care for 90 days or more a new referral will be required.
- I agree to provide up to date insurance information.
- A sick child, sibling or parent should not attend therapy. For cancellations due to illness, please contact our office as soon as possible.
- I agree to notify the therapist at least two weeks in advance of vacations or an extended leave of absence during my child's scheduled treatment sessions.

#### Communication

- My family and I commit to courteous and respectful behaviors with our team members, including our admin team as well as clinicians. I understand that CHKD cannot continue treatment for families who cannot show respectful language and behavior, including swearing, threatening, or bullying language or behaviors. For these families, information about alternate treatment options will be offered.

**CHKD commits that our team will**

- Communicate and interact in safe, timely respectful manner.
- Reschedule as soon as possible if your therapist needs to cancel or re-schedule an appointment
- Maximize your child's success through evidence-based treatment
- Send a text, email, or call to remind you of your visit
- Provide 24-hour coverage through the CHKD Emergency Department in the event of a mental health emergency after hours
- Provide information about alternate community resources for families not able to participate fully and respectfully.
- CHKD will provide crisis follow up within 48-hours of an emergency department visit as requested

\_\_\_\_\_  
Caregiver signature  
Updated: 11/17/2020

\_\_\_\_\_  
Date



CHKD Mental Health Service Line  
 601 Children's Lane  
 Norfolk, VA 23507  
 757.668.HOPE



Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

### Mental Health Service Line Patient Questionnaire

**Thank you for taking the time to provide this very important information, which we will review with you at your child's visit.**

Child's name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_

Legal Guardian Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Preferred telephone number: \_\_\_\_\_ Email address: \_\_\_\_\_

Child's age: \_\_\_\_\_ Child's DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Gender: \_\_\_\_\_

Referring physician: \_\_\_\_\_ City: \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Name of practice: \_\_\_\_\_

### Current Concerns

Please briefly share up to 3 of the most important concerns/stressors and when it first occurred.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### Pregnancy/Childhood History

#### History of Pregnancy & Birth:

What was the mother's age at the time of pregnancy? \_\_\_\_\_

Did the mother drink / take alcohol, smoke or use drugs during pregnancy?  No  Yes

Where there any illnesses during pregnancy or postpartum period (including depression)?  No  Yes

If yes, explain? \_\_\_\_\_

Was the pregnancy full term?  No  Yes If no, what was the number of weeks or months? \_\_\_\_\_

What was the birth weight? \_\_\_\_\_

Delivery Type

<input type="radio"/> C-Section	<input type="radio"/> Vacuum
<input type="radio"/> Forceps	<input type="radio"/> Vaginal

Any complications at birth?  No  Yes If yes, explain? \_\_\_\_\_

Any special care given in the hospital?  No  Yes

If yes, explain \_\_\_\_\_

Were mother and baby discharged together?  No  Yes

If yes, explain \_\_\_\_\_

Does your child have a twin?  No  Yes      Is your child adopted?  No  Yes

History of post partum depression :      Mother  No  Yes      Dad  No  Yes

### Developmental Milestones

Sleep all night    age: \_\_\_\_ Months      Comment: \_\_\_\_\_

Sat up    age: \_\_\_\_ Months      Comment: \_\_\_\_\_

Walked    age: \_\_\_\_ Months      Comment: \_\_\_\_\_

Bowel trained    age: \_\_\_\_ Months      Comment: \_\_\_\_\_

Bladder trained    age: \_\_\_\_ Months      Comment: \_\_\_\_\_

Say single word    age: \_\_\_\_ Months      Comment: \_\_\_\_\_

### School/Daycare History

Name of current school or childcare: \_\_\_\_\_      Grade (if applicable): \_\_\_\_\_

How is your child's performance in school?: Comments: \_\_\_\_\_

Does your child receive any accommodations or supports: Yes [ ] No [ ] Comments: \_\_\_\_\_

Previous testing at school (psychological, psychosocial, IEP, gifted):    Yes [ ] No [ ] Comments: \_\_\_\_\_

Does your child have/has your child ever had a : [ ] IEP [ ] 504 [ ] Reading support [ ] Other

Current or previous homebound instruction?       No  Yes    If yes, explain? \_\_\_\_\_ \

Has your child ever repeated any grades?       No  Yes    If yes, explain? \_\_\_\_\_

Has your child skipped any grades?       No  Yes    If yes, explain? \_\_\_\_\_

### Social History

Do you have any concerns about your child's ability to make/keep friends? Yes [ ] No [ ]

If yes, please explain \_\_\_\_\_

### Adolescent Health: (female only)

Has your child's menstrual periods started?  No  Yes    If yes, at what age did they begin? \_\_\_\_\_ years

### Adolescent Health:

Is the child sexually active?       No     Yes     Not Sure

### Recent Changes

Please briefly share 3 changes in your child's life.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Medical History:** Has your child ever had

- Accidents/Trauma Yes  No  Comments: \_\_\_\_\_
- Appetite problems Yes  No  Comments: \_\_\_\_\_
- Birthmarks Yes  No  Comments: \_\_\_\_\_
- Change in coordination/speech Yes  No  Comments: \_\_\_\_\_
- Chronic Illness or serious medical problems Yes  No
- Comments: \_\_\_\_\_
- Gastro/constipation problems Yes  No  Comments: \_\_\_\_\_
- Headaches Yes  No  Comments: \_\_\_\_\_
- Head Injury Yes  No  Comments: \_\_\_\_\_
- Heart problems Yes  No  Comments: \_\_\_\_\_
- Hospitalizations or operations Yes  No  Comments: \_\_\_\_\_
- Seizures/convulsions Yes  No  Comments: \_\_\_\_\_
- Sinus infections Yes  No  Comments: \_\_\_\_\_
- Sleep Problems Yes  No  Comments: \_\_\_\_\_
- Speech problems Yes  No  Comments: \_\_\_\_\_
- Vision problems Yes  No  Comments: \_\_\_\_\_

**Has your child ever**

Witnessed something scary (violence in the home or community, natural disaster, frightening or invasive medical procedure or other event)? Yes  No

- Family history of heart attack or stroke before age 40 Yes  No
- Any concerns related to alcohol/drug use? Yes  No
- Has your child ever been Emotional/Physically/Sexually abused? Yes  No
- Child protection services involvement? Yes  No
- Are there firearms in the home? Yes  No
- Has your child ever witnessed domestic violence? Yes  No
- Any Custody/Court Concerns? Yes  No

**Current Systems Check:** Please check any symptoms or problems your child has experienced **in the past 2 weeks** and share any comments as necessary.

		Yes	No	Comments
<b>General</b>	Weight changes, energy or activity changes, appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Skin</b>	Rash, itching, acne	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Neurologic</b>	Headaches, dizziness, fainting, seizures, tics, concussion, speech changes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Eyes, Ears, Nose, Throat</b>	Ringling in ears, hearing loss, blurred vision, sore throat, swallowing difficulties, tooth pain, bloody nose	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Heart/Lungs</b>	Breathing problems, chest pain, heart racing/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Muscles/bnoes</b>	Joint pain, swelling, muscle weakness, injuries	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Digestion</b>	Nausea, vominting, diarrhea, constipation, heartburn, abdominal pain, problems with bowel movements, changes in eating and drinking	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Genitourinary</b>	Problems with urination, urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Endocrine</b>	Problems with menstrual periods, breast pain, breast discharge, heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Psychiatric</b>	Mood changes, behavior changes, anxiety, worries, hallucinations, sleep changes	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Allergies</b>	Seasonal allergies, major allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Blood</b>	Bleeding, bruising	<input type="checkbox"/>	<input type="checkbox"/>	

**Additional Services/Testing** Has your child had any of the following (now or in the past)? (Please bring any results to appointment)

Physical therapy [ ]      Occupational therapy [ ]      Speech therapy [ ]

EEG testing [ ]      Brain scan (MRI/CT) [ ]      Chromosomes or Fragile X testing [ ]

Outpatient Mental health Services: \_\_\_\_\_

Psychological or cognitive Evaluation/Testing: \_\_\_\_\_

Partial Hospitalization/Intensive outpatient/Inpatient Hospitalizations: \_\_\_\_\_

Genetic Testing: \_\_\_\_\_









**CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS  
HEALTH SYSTEM, INC.**

**AUTHORIZATION TO GIVE CONSENT  
FOR MEDICAL TREATMENT**

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Child/Patient Name: _____				
Date of Birth: _____		Medical Record Number: _____		
<p>Until revoked by me in writing, the following persons are authorized to act on my behalf:</p> <ol style="list-style-type: none"> <li>(1) to give consent to medical and/or diagnostic treatment, including admission and surgery if deemed necessary, by Children's Hospital of The King's Daughters, Inc., ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG") of my child named above;</li> <li>(2) to give consent for testing my child's blood for HIV antibodies in accordance with the laws of Virginia which authorize health care providers to test patients when a health care provider is exposed to the body fluids of a patient;</li> <li>(3) to assign benefits of third party payors for direct payment to CHKDHS and/or CSG; and</li> <li>(4) to receive financial information regarding my child's health care and/or medical information about my child's condition, treatment or health care received at CHKDHS and/or CSG.</li> </ol> <p>I agree that the following persons, 18 years of age or older, are authorized to sign on my behalf thus acknowledging the following statement and binding me to its terms in my absence: The undersigned parent and/or legal guardian agree that in consideration of services rendered to the patient, each of them jointly and severally, will pay and guarantee payment to CHKDHS and/or CSG. I furthermore irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered. I understand my insurance policy is a contract between my insurance company and me, and I am responsible to CHKDHS and/or CSG for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand I will receive a separate statement and bill from the laboratory or radiology department performing the test. Upon default on any payment due to CHKDHS and/or CSG, I agree to pay all cost of collections, including collection agency fees up to 33-1/3% and/or any reasonable attorney's fees, if applicable.</p> <p>Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of \$25.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. Please direct all billing inquiries to the CHKDHS and/or CSG Billing Representative where you received your care.</p>				
<b><u>AUTHORIZED PERSONS:</u></b>				
First Name	MI	Last Name	Relationship to Child	Date
_____	_____	_____	_____	_____
First Name	MI	Last Name	Relationship to Child	Date
_____	_____	_____	_____	_____
First Name	MI	Last Name	Relationship to Child	Date
_____	_____	_____	_____	_____
Parent/Legal Guardian			Date	
_____			_____	
Parent/Legal Guardian			Date	
_____			_____	
Witness			Date	
_____			_____	



**Children's Hospital of The King's Daughters Health System**

601 Children's Lane, Norfolk, VA 23507

**CONSENT FOR TELEHEALTH  
CONSULTATION**

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

I hereby request and consent to medical and/or diagnostic treatment in a telehealth consultation arranged by Children's Hospital of The King's Daughters, Incorporated ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG") and hereby authorize such entities and their physicians (and whomever he/she may designate as his/her assistant(s), including Residents and any CHKD staff physician) and employees to treat me, my child, or a minor in my legal custody ("Patient") upon presentation of necessary supporting documentation, in a telehealth visit with an outside consultant.

I understand that my health professional offered for me to participate as a Patient in a telehealth consultation at Children's Hospital of The King's Daughters with

Name of Practice: \_\_\_\_\_, with the names and credentials of individual practitioners found at [www.chkd.org](http://www.chkd.org), which are incorporated in this Consent.

I understand that:

- 1) I, the Parent/Legal Guardian/Patient, and/or my health care professional(s) at CHKDHS and/or CSG will through interactive video conferencing be able to consult with the consultant about my condition who may offer medical and/or diagnostic treatment. Moreover, I agree that it is the role of the health care professional to determine whether the condition being diagnosed and/or treated is appropriate for a telehealth encounter.
- 2) The telehealth consultant practices in a different location and does not have the opportunity to meet with me face-to-face. Therefore, she/he must rely on information provided by me and my onsite healthcare professional(s). The CHKDHS and/or CSG providers and affiliated telehealth consultant cannot be responsible for advice, recommendations and/or decisions made based on incomplete or inaccurate information provided by me or others.
- 3) Other individuals may be present to operate the video equipment to facilitate this consultation, and their participation along with all involved health providers will be pursuant to federal and state health privacy laws.
- 4) A limited physical examination may be conducted during the videoconference, some portions of which may be conducted by health professionals at my location at the consultant's direction.
- 5) I may request that the telehealth consultation and/or videoconference be discontinued at any time without affecting my right to future care or treatment.
- 6) I know there are potential risks with the use of this technology. These risks include but are not limited to:
  - a) Interruption of the audio/video link;
  - b) Disconnection of the audio/video link;
  - c) A picture that is not clear enough for medical decision-making by my health care professionals, including the consultant; and/or
  - d) Electronic tampering resulting in a breach of privacy of patient health information.
- 7) If any of these risks occur, the telehealth consultation may need to be stopped, which could lead to a delay in medical evaluation and treatment. In addition, I may be required to go to the location of the telehealth consultant to further facilitate my diagnosis.
- 8) In conjunction with the telehealth consultation, digital images may be made and sent to physicians and/or other health care professionals at CHKDHS and/or CSG for evaluation and consultation with my telehealth consultant for medical and/or diagnostic treatment purposes.

By signing this consent, I authorize the Patient's health professionals, including the telehealth consultant, to release any relevant medical information pertaining to the Patient's medical condition and medical care to CHKDHS and/or CSG physicians and/or associated health care professionals for continuing care purposes. I authorize CHKDHS and/or CSG to release any and all necessary information to the Patient's insurance company or any other agent which may be responsible for paying the Patient's medical bills. I authorize the use of electronics as described to facilitate the telehealth consultation and release CHKDHS and CSG from any and all past, present, or future claims, demands, liabilities, actions, causes of action, or suits of any kind directly or indirectly arising out of or involving the use of such technology, including any loss of information due to technical failure and/or decision on my part to discontinue the consultation prematurely.

I have carefully read and understand this Telehealth Consent, discussed it with my health professional and/or such assistants as designated, and all questions have been answered to my satisfaction. I have been given no guarantee or assurance as to the results that may be obtained. I certify that I am the Patient or the Patient's parent or legal guardian, and I have the authority to grant this consent and hereby consent to the Patient's participation in the telehealth consultation under the terms described above.

*Thank you for selecting Children's Hospital of The King's Daughters Health System as your Health Care Provider.*

PATIENT NAME		DATE OF BIRTH	
SIGNATURE OF PARENT	RELATIONSHIP TO PT/LEGAL AUTHORITY	DATE	TIME
WITNESS SIGNATURE		DATE	TIME

**For Office Use only:**

2ND WITNESS (VERBAL CONSENT ONLY)	DATE	TIME	NAME OF PERSON ACCOMPANYING PATIENT
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**Children's Hospital  
of The King's Daughters**  
**Health System**

CHKD Mental Health Service Line  
601 Children's Lane  
Norfolk, VA 23507  
757.668.HOPE

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**Emergency Contact Information for Unaccompanied Minors**

I \_\_\_\_\_ (parent/guardian) completed an Unaccompanied Minor form  
for \_\_\_\_\_ (child's name).

My contact information is as follows: (cell phone, work phone, home phone options listed)

In the event of an emergency during the appointment, your child's therapist will attempt to contact you. If the therapist is unable to contact you, you are providing consent for our therapist to contact the following people in the order they are listed.

- 1. Name \_\_\_\_\_ Phone \_\_\_\_\_
- 2. Name \_\_\_\_\_ Phone \_\_\_\_\_
- 3. Name \_\_\_\_\_ Phone \_\_\_\_\_

Please note that the above named individuals will be contacted only if there is a medical or mental health emergency for which a decision needs to be made regarding the minor child's care and you are unavailable.

By signing, you are acknowledging that it is your responsibility to ensure that the CHKD Mental Health Service Line has your updated contact information and the updated contact information of the above named individuals.

Staff \_\_\_\_\_

Date \_\_\_\_\_

Parent \_\_\_\_\_

Date \_\_\_\_\_

Patient \_\_\_\_\_

Date \_\_\_\_\_



Children's Hospital of The King's Daughters, Inc.  
601 Children's Lane, Norfolk, VA 23507-1910

**PATIENT/HEALTH CARE PROVIDER  
E-MAIL/TEXTING CONSENT**

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**1. RISKS OF USING E-MAIL AND TEXT MESSAGING**

CHKDHS offers patients, parents or guardians the opportunity to communicate by e-mail or text messaging. Using e-mail to discuss patient information, however, is different than phone messaging. Text messaging is not to be used to convey medical information or to discuss medical conditions. E-mail and/or text message communication has a number of possible risks that patients, parents or guardians should consider before using e-mail or text messaging. If the patient, parent or guardian is worried about any information being seen by other people, or if the question or problem is urgent, other form(s) of communication such as telephone communication should be used. Some of the possible risks of using email or text messaging include, but are not limited to, the following:

- a. E-mail information or text messages can be sent on to other people, stored on a computer, or printed out on paper for storage.
- b. E-mail or text messages can be sent out and received by many recipients, some or all of whom may be sent the e-mail accidentally.
- c. E-mail or text message senders can easily misaddress their message.
- d. E-mail or text message information is easier to change than handwritten or signed documents.
- e. E-mail or text message information may be kept on computers/electronic devices even after the sender or the recipient believes they deleted his or her copy.
- f. Employers and on-line services have a right to archive (store) and look at e-mails/text messages transmitted through their systems. Some, but not all, employers store e-mail/text messages indefinitely.
- g. E-mail/text messages can occasionally be intercepted, changed, forwarded, or used without authorization or detection.
- h. E-mail or text messages can be used to introduce viruses into computer systems.
- i. E-mail or text messages can be used as evidence in court.

**2. CONDITIONS FOR THE USE OF E-MAIL AND TEXT MESSAGING**

The health care providers will use reasonable means to protect the security and confidentiality of e-mail/text message information sent and received. However, because of the risks outlined above, the health care providers cannot guarantee the security and confidentiality (privacy) of e-mail/text messaging communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996). Thus, the patient, parent or guardian must consent to the use of e-mail for patient information. Consent to the use of e-mail/text messaging includes agreement with the following Conditions:

- a. E-mails to or from the patient, parent or guardian concerning diagnosis or treatment will be printed out and/or made part of the patient's medical record. Because they are then a part of the medical record, other individuals who are authorized to view the medical record, such as staff and billing personnel, will also have access to those e-mails.
- b. The health care providers may forward e-mails/text messages internally to other staff or agents of the health care providers/their practice as necessary for diagnosis, treatment, reimbursement, and other operations. The health care providers will not, however, forward e-mail or text messages to independent third parties outside of CHKD who are not involved with the patient's treatment, reimbursement, or otherwise involved in their care, without the patient's prior written consent, except as authorized or required by law. The health care providers may possibly forward e-mail/text messages to other health care providers participating in the patient's care.
- c. Although the health care providers will try to read and respond quickly to an e-mail or text message from the patient, parent or guardian, the health care providers cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. The usual period of time is less than one business day, but it may take up to a week or longer if the person to whom the e-mail is sent is away or if the e-mail system is not working. Thus, the patient, parent or guardian should not use e-mail for medical emergencies or other matters that have to be handled quickly.
- d. Text messages are used by health care providers for appointment reminders or to share more generic information. When text messages are sent by a patient, parent or guardian there should not be an expectation of a response from the health care provider.

- e. If the patient's, parent's or guardian's e-mail requires or invites a response from the health care provider, and the patient, parent or guardian has not received a response within a reasonable time period, it is the patient's, parent's or guardian's responsibility to call the practice in order to determine whether the intended recipient received the e-mail and when the recipient will respond. As an alternative, the patient, parent or guardian can discuss the issue by telephone.
- f. The patient, parent or guardian should not use e-mail or text messages to discuss any subjects that the patient, parent or guardian feels should be kept confidential, such as sensitive medical information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- g. Where applicable, there may be a physician charge for the time necessary to respond to the e-mail.
- h. The patient, parent or guardian is responsible for protecting his/her password or other means of access to e-mail or text messaging. The health care provider or his practice is not liable for information that is read by other people through errors caused by the patient or any third party.
- i. The health care provider or his practice cannot engage in e-mail or text message communication that is unlawful, such as practicing medicine across state lines.
- j. If through e-mail or text message communication, the health care provider determines that an office or hospital visit is necessary to address the problem, or if the patient, parent or guardian wants to have such a visit, it is the patient's, parent's or guardian's responsibility to schedule the appointment.

**3. INSTRUCTIONS**

To communicate by e-mail or text message, the patient, parent or guardian is advised to:

- a. Limit or avoid use of his/her employer's computer. Information is often stored on the employers system and can be read by people within that organization.
- b. Inform the health care provider/Practice of changes in e-mail or text messaging addresses.
- c. To help the health care provider and practice ensure that they are communicating about the right person, put the patient's full name and date of birth in the body of the **first** e-mail message to the physician and/or practice and not in the subject line.
- d. In order for the e-mail to be forwarded to the proper person, include the category of the communication in the e-mail's subject line, (e.g., "I have a laboratory test question"). For instance, a billing question sent to the doctor may be forwarded to the practice manager.
- e. Review the e-mail or text message to make sure it is clear and that all needed information is provided before sending to the health care provider/Practice.
- f. E-mails from health care providers will be encrypted. The first time you receive an email you will get a notice email from ZixCorp and you will have to set up your user name and password with them. This user name and password will be required to access the first and all future emails.
- g. When you receive an e-mail from the health care provider/Practice, please send a reply that it was received so that the health care provider/Practice knows that the e-mail arrived to the correct location.
- h. Take precautions to preserve the confidentiality of e-mails or text messages, such as using screen savers and safeguarding computer passwords.
- i. Withdraw consent only by e-mail or written communication to the health care provider/Practice.
- j. Contact the health care provider or the practice at their provided telephone number with any questions about using e-mail or text messaging. This should be done before sending an e-mail to the health care provider/Practice.

**4. PATIENT ACKNOWLEDGMENT AND AGREEMENT**

I acknowledge that I have read and fully understand the information the health care provider/Practice has provided me regarding the Risks of using e-mail or text messaging. I understand the Risks associated with the communication of e-mail or text messages between the health care provider/Practice and me, and consent to the Conditions outlined. In addition, I agree to the above instructions, as well as any other instructions that the health care provider/Practice may impose regarding e-mail or text message communications.

E-mail address: \_\_\_\_\_

Cell phone number for texting: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*-Dr Declined*



CHKD Mental Health Service Line  
 601 Children's Lane  
 Norfolk, VA 23507  
 757.668.HOPE

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**Mental Health Program Participants:**

Thank you for choosing the Mental Health Program at Children's Hospital of the King's Daughters. Your child's success is important to us. A Mental Health Therapist will conduct an initial intake evaluation to determine whether your child's needs fall within our scope of practice. If your child's needs fall outside of our scope of practice, we will connect you to community mental health resources.

**Insurance Information:** You MUST contact your insurance company to inquire about your "Medical Mental Health/Outpatient Counseling benefits" prior to your appointment. Insurance companies will provide you with your benefit coverage, pre-authorization or co-pay/co-insurance requirements, along with other billing questions. Our clinicians are providers of the health system, so please keep in mind that your co-pay or co-insurance obligation may fall under your medical benefit. Also evidence based screening tools may be used throughout the course of therapy and are necessary for success in treatment. Please be aware that you may incur an additional charge and if you have any concerns please contact your insurance company.

**Tele-health encounter:** Today's visit will count as a second, separate visit from your medical visit. It will be billed separately to your insurance and if your insurance has a co-pay or co-insurance you will be responsible for this fee. There is no prior authorization needed for assessment services via **tele-health encounter**; however, you will be obligated to pay a co-pay or co-insurance dependent upon your child's individual benefits.

**Length of treatment:** Our mental health program provides short-term (12-18 sessions) counseling. If our clinician recommends extended counseling to meet your child's specific needs, additional resources may be provided. Completing or being discharged from our program does not mean you are being discharged from the CHKD specialty clinic from which you were referred.

**Limits of confidentiality:** We ask that you please review the "Notice of Privacy Practices" pamphlet provided to you. In the event that you or your child articulate any "serious threat to health or safety" or "public health activity" matters to our clinician, including but not limited to: suspected child abuse or neglect, sexual abuse, thoughts or plans of self-harm, thoughts or plans to harm others, our clinician is mandated to report these matters to local agencies and take action to ensure the safety of the child and/or affected party. Clinician notes and patient diagnoses are shared with CHKD treating physicians.

**Diagnoses:** If a third party such as an insurance company is paying for part of your bill, clinicians normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your concerns discussed in treatment. All diagnostic codes are explained and listed on insurance billing forms.

**Conditions for discharge from program:** Our mental health therapists may consider discharge of patient/family for treatment non-compliance (e.g. chronic lateness, three cancellations/no shows, disrupting office flow, presenting for sessions while under the influence, not following treatment recommendations to ensure patient safety). A discussion with you will take place prior to this and we will bridge care until appropriate care in the community is located.

**Psychology Intern/Medical Social Worker/Resident in Counseling:** Our Mental Health Program may provide non-billable services/billable services with professionally qualified staff with a Master's degree in psychology, social work, or counseling under direct supervision. The supervisor may be present in some or all sessions in our Mental Health Program, for an allotted amount of time based on ethical standards. Please inquire if this is of interest to you and your family.

Name of Resident/Supervisee: \_\_\_\_\_  
 Name of Licensed Supervisor: \_\_\_\_\_  
 Contact Information of Supervisor (address/phone#): \_\_\_\_\_

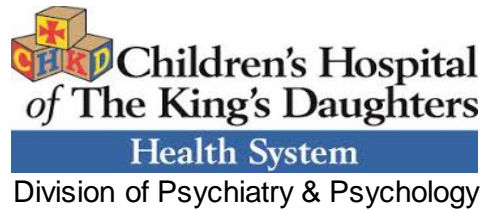
We look forward to working with you and your family to help you achieve your health and mental health goals.

Staff \_\_\_\_\_ Date \_\_\_\_\_

Parent \_\_\_\_\_ Date \_\_\_\_\_

Patient (**if over age 14**) \_\_\_\_\_ Date \_\_\_\_\_

400 Gresham Drive  
Medical Tower  
9th Floor, Suite 907  
Norfolk, VA 23507  
757-668-4673  
757-668-8870 Fax



## Prescription Refill Policy

Please be aware that:

- Refill requests can be
  1. Requested by calling 757-668-4673 and choosing option 3 then follow the prompt to your child's provider
  2. Requested by emailing [psychiatry@chkd.org](mailto:psychiatry@chkd.org)
  3. Requested by completing online at our website <http://www.chkd.org/psychiatry>
    - Go to [www.chkd.org/psychiatry](http://www.chkd.org/psychiatry) and click "request a prescription refill" under the useful links located on the right side.
    - Log in or create an account.
    - Enter in all the required fields and select continue.
- All refills require at least 48 hours' notice on regular business days. Prescriptions can not be refilled on the weekends, evenings or holidays.
- The following information is required for ALL refill requests
  1. Your child's name
  2. Your child's date of birth
  3. Your name and current/best contact number
  4. Name of medication, current dose and frequency
  5. Current pharmacy name AND location/address
- Some refills may require an Insurance Preauthorization; this may require addition time
- Medications, including controlled medications, are now called directly in to the pharmacy if appointments are up to date. DoD is not currently taking controlled medications electronically from outside providers. These prescriptions must be picked up by a parent or guardian with a picture ID, mailed to your home address on file or sent to an outside pharmacy. **Please note the pharmacy will now notify you (not Psychiatry & Psychology) when these medications are ready for pick up, so please insure you are registered for updates from your pharmacy.**
- A refill request requires a face-to-face visit every 3 months.
- Some medications require monitoring bloodwork or other diagnostic testing, which we may request you receive prior to refill

I have read the above and understand the Prescription Refill Policy and my responsibilities for obtaining refills for my child(ren).

\_\_\_\_\_  
Parent/Guardian Signature & Print Name / Date

\_\_\_\_\_  
Witness Signature & Print Name / Date

Patient Label
---------------



## Division of Psychiatry and Psychology

### Review of systems

Child's Name:

Today's Date :

Please check any symptoms or problems your child has experienced **in the past 2 weeks** and share any comments as necessary.

		None	Yes	Comments
General	Weight changes, energy or activity changes, appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	Rash, itching, acne	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic	Headaches, dizziness, fainting, seizures, tics, concussion, speech changes	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes, Ears, Nose, Throat	Ringing in ears, hearing loss, blurred vision, sore throat, swallowing difficulties, tooth pain, bloody nose	<input type="checkbox"/>	<input type="checkbox"/>	
Heart/Lungs	Breathing problems, chest pain, heart racing/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
Muscles/bnoes	Joint pain, swelling, muscle weakness, injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Digestion	Nausea, vominting, diarrhea, constipation, heartburn, abdominal pain, problems with bowel movements, changes in eating and drinking	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	Problems with urination, urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	Problems with menstrual periods, breast pain, breast discharge, heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric	Mood changes, behavior changes, anxiety, worries, hallucinations, sleep changes	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	Seasonal allergies, major allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>	
Blood	Bleeding, bruising	<input type="checkbox"/>	<input type="checkbox"/>	



**CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS  
CHILDREN'S SPECIALTY GROUP  
CHILDREN'S SURGICAL SPECIALTY GROUP  
CHILDREN'S MEDICAL GROUP**

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**STATEMENT OF FINANCIAL RESPONSIBILITY WAIVER**

- CHKD  **Children's Specialty Group**  Children's Surgical Specialty Group  Children's Medical Group

**You will receive services today with the understanding that you will be held financially responsible for the full amount charged in the event the insurance coverage information you provided at the time of service is not effective for the date of service, a valid referral is not received for the services provided, or the services are not a part of your benefit plan, including services deemed not medically necessary.**

**CHECK ALL THAT APPLY:**

- Positive verification of your exact **Medicaid Health Insurance** coverage cannot be made at this time. You will receive services today with the understanding that your account will be in a self-pay status until we receive verification of your health insurance coverage. Your effective date must be on or prior to the date of service. A provider from our practice should be listed as your Primary Care Physician (PCP) if applicable.
- Positive verification of your insurance coverage listing a provider from our office as your **Primary Care Physician** cannot be made at this time. You will receive services today with the understanding that your account will be in a self-pay status until we receive verification of your health insurance coverage. Your effective date must be on or prior to the date of service. A provider from our practice should be listed as your Primary Care Physician (PCP).
- Your account will be in a self-pay status until a **valid referral** for today's services is received. You understand that retroactive referrals are not allowed by your health plan.
- Your account will be in a self-pay status until **your child is added** to your health insurance policy. This should be completed within 30 days of his/her date of birth. The effective date of coverage for your child must cover the date(s) of service.
- Your account will be in a self-pay status until a **valid insurance card** is presented to our office and insurance verification can be obtained.
- One or more of the services received today may not be covered by my insurance plan; I will be financially responsible for the services(s) and/or supplies listed.**

<u>Services/Supplies</u>	<u>Estimated Cost of Service(s)</u>
<u>Telephone Consultation</u>	<u>\$ 50 - \$ 200</u>
_____	_____
_____	_____

- Services deemed not medically necessary.
- Parent/Guarantor refused to sign.

I have read the above statement and understand my financial responsibility and hereby affix my signature as acknowledgement of this understanding. I certify that I am the patient, the patient's parent or legal guardian and have the authority to sign this waiver.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Patient / Guarantor Signature

\_\_\_\_\_  
Date / Time

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date / Time



Children's Hospital of The King's Daughters Health System

TREATMENT AND PAYMENT ACKNOWLEDGMENT/CONSENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

CONSENT FOR TREATMENT

I hereby request and consent to medical and/or diagnostic treatment, including admission if deemed necessary, by Children's Hospital of The King's Daughters, Incorporated ("CHKD"), Children's Medical Group, Inc. ("CMG"), Children's Surgical Specialty Group, Inc. ("CSSG") (CHKD, CMG, and CSSG are collectively referred to herein as "Children's Hospital of The King's Daughters Health System" or "CHKDHS") and/or Children's Specialty Group, PLLC ("CSG"), and hereby authorize such entities and their physicians (and whomever he/she may designate as his/her assistant(s), including Residents and any CHKD professional staff physician) and employees to treat myself or minor(s) in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, and medical or surgical procedures. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. Virginia law authorizes health care providers to test patients for HIV and Hepatitis B & C antibodies when a health care provider or any person employed by or under the direction and control of a health care provider is exposed to the body fluids of a patient in a manner that may transmit HIV or the Hepatitis A or B viruses. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to my physician or healthcare provider. I further consent to the taking of photographs for treatment and/or payment purposes. Date: \_\_\_\_\_ Initials: \_\_\_\_\_

OBLIGATION OF PAYMENT

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CHKDHS and/or CSG for services rendered. I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to CHKDHS and/or CSG for any charges not covered by my insurance, including co-payments, deductibles, and fees for non-covered services. Since most physicians are not employed by the hospital, the hospital and physician will bill separately for services rendered. Some insurance plans require the laboratory and/or radiology department performing tests to bill for such diagnostic tests. In these instances, I understand that I will receive a separate statement and bill from the laboratory and/or radiology department performing the test. If all charges are not paid when due to CHKDHS and/or CSG, the undersigned agrees to pay all costs of collection, including collection agency and attorney's fees in an amount not to exceed THIRTY THREE AND ONE-THIRD PERCENT (33 1/3%) of the balance placed with agency and attorney, which shall be deemed incurred upon referral. Date: \_\_\_\_\_ Initials: \_\_\_\_\_

BALANCES DUE AND BILLING QUESTIONS

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the hospital and/or practice. I have been informed that a fee of \$25.00 may be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. All billing inquiries can be directed to the CHKDHS and/or CSG Billing Representative where care was received. Date: \_\_\_\_\_ Initials: \_\_\_\_\_

COMMUNICATION PREFERENCE

• If the email address is provided, I consent to CHKDHS' and/or CSG's use of unsecured email to send me communications that may include protected health information.
• If the mobile phone number is provided, I consent to CHKDHS and/or CSG's use of unsecured text messaging to send me communications that may include protected health information.
By signing this consent form, I acknowledge that I have the authority to provide consent and am granting permission to CHKDHS and/or CSG to contact me for any reason on the mobile phone number(s) provided. I understand that I may choose to grant permission to contact me via phone call and text message, or phone call only (no texts). Consent is not required; I may opt-out of contacts to my cell phone number. I retain the right to revoke permission at any time. I understand that contacts may be made as a direct dial call or through the use of text messages, pre-recorded or artificial voice messages, and/or the use of an "automated telephone dialing system" or "autodialer". Depending on my mobile service plan, message and data rates may be assessed by my mobile provider. I may withdraw consent or opt-out at any time by providing written notice to Physician Practice Management, by emailing Text.Opt@chkd.org, by calling CHKD at (757) 668-8577, or by visiting our website at www.chkd.org/TextOpt. Responding to text messages with "STOP" will also withdraw my consent. I understand that the person signing is not required to sign the agreement as a condition of securing any services with CHKDHS and/or CSG. Date: \_\_\_\_\_ Initials: \_\_\_\_\_

ACKNOWLEDGMENTS/CERTIFICATIONS

I, the Parent/Legal Guardian/Patient, acknowledge and certify the following:
• I received a medical screening and stabilization treatment prior to being asked about financial information while seeking care for a deemed medical emergency.
• I was offered (a) the "Patient/Family Rights & Responsibilities" form and provided (b) the Organized Healthcare Arrangement "Notice of Privacy Practices" form on the date of this Agreement and was given an opportunity to ask questions about the information provided.
• I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the payment terms contained in this form.
I certify that this form has been fully explained to me, that I have had any necessary communication assistance, I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws. Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Advance Directive to be completed if patient is an adult (18 years or older): Does the patient have an advance directive? \_\_\_ Yes \_\_\_ No

Thank you for selecting Children's Hospital of The King's Daughters Health System as your Health Care Provider

PATIENT(S) NAME (please print):

DATE OF BIRTH:

SIGNATURE OF PATIENT/LEGAL GUARDIAN

RELATIONSHIP TO PATIENT/LEGAL AUTHORITY

DATE

TIME

Witness: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

For office use only:

2nd Witness: (Verbal Consent Only)

Date

Name of Person Accompanying Patient



Children's Hospital of The King's Daughters Health System

UNACCOMPANIED MINOR AUTHORIZATION TO OBTAIN MEDICAL TREATMENT

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

The health of our patients is very important to us. We believe the parent/legal guardian is very important in promoting and maintaining the health of a minor. It is our recommendation that a parent/legal guardian or authorized adult be present during the deliver of healthcare services. However, we acknowledge minor are developing independence in meeting their own healthcare needs and that there are times when an authorized adult is unable to accompany the minor during the delivery of healthcare services. Therefore, we offer this authorization, which allows a minor, 14 years or older to obtain healthcare services when an authorized adult is unable to accompany a minor for the provision of healthcare services.

Until revoked by me, the parent/legal guardian identified below, verbally in person or in writing and delivered to the service area/practice personnel specified above, the minor established patient, 14 years of age or older, identified below has my permission to seek general medical, diagnostic, routine minor medical procedures and other related healthcare services without the presence of a parent/legal guardian. Services include but are not limited to:

- 1) examination, obtaining specimens, laboratory testing, diagnostic testing, medication administration and routine minor medical procedures;
2) testing of the minor's blood for HIV antibodies in accordance with state laws (Deemed Consent) which authorize health care providers to test patients when a health care provider is exposed to the body fluids of a patient.

I hereby authorize the physicians, employees, and other designated assistants affiliated with CHKD to treat the minor patient identified below, as deemed medically/therapeutically necessary and agree:

- 1) the minor patient, identified below, is authorized to sign on my behalf for the aforementioned medical care and services;
2) to guarantee payments including click on-payments and deductibles, in accordance with the regular terms and charges of the service area/practice, specified above, as consideration for services rendered to the minor patient under this authorization;
3) any portion of the bill not covered by insurance will be payable at the time of service unless other arrangements are made;
4) in the event of non-payment, the services area/practice, specified above, has the right to proceed against me or the responsible party(ies) without making any demands of, or taking any action or proceeding against each other as a prerequisite.
5) to pay all costs of collections, including collection agency fees up to thirty three and one-third percent (33-1/3%) of the amount owed.

PRINT First Name MI Last Name Relationship to child DOB

PRINT First Name MI Last Name Relationship to child DOB

PRINT First Name MI Last Name Relationship to child DOB

Parent/Legal Guardian SIGNATURE Date

Parent/Legal Guardian SIGNATURE Date

Witness SIGNATURE Date

Notary Seal

Date: \_\_\_\_\_

Notary Signature: \_\_\_\_\_

A Notary is required if this form is not signed/witnessed in the presence of an employee of the service area/practice.