Client Name: _____

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Child Registration

Office Use Only (Registration Worker)

Date Registration Submitted to Office:		1st Intake Appointment Offered:			
		Fee Code (Medicaid, Private Insurance Company, Fee):			
911/DI Worker:	DATE:				
		Case #:			
			Therapy		Group:
			Diagnostic Testing		CPST
			Day Treatment		Juvenile Court Intensive HB
			Therapeutic Foster Care		Psychiatric Evaluation
			School Contract Therapy (Prgm 76)		Other:
Legal Custodian of Client:					

PLEASE PRINT - Please read and fill out ALL sections.

Child's Information		
Legal Name (last, first, middle):		Preferred/Chosen Name:
Pronouns:	Gender:	Sex assigned at birth:
SS#:	Age:	DOB:
Primary Language if other than English:		

Name of School that Child Attends:		Current Grade in School:	

	Child's Race: (Check All that apply):
	Alaskan Native
	Asian
	Black/ African American
	Native American/American Indian
	Native Hawaiian / Other Pacific Islander
	White
	Biracial:

	Child's Ethnicity: (Check All that apply):
	Cuban
	Mexican
	Puerto Rican
	Other Hispanic
	Not Hispanic or Latino

Guardian(s) / Legal Custodian(s) Information:		
Name:		Pronouns:
Street Address:		DOB:
Mailing Address:		County of Residence:
City:	State:	Zip:
Home #:	Work #:	Cell #:
Email address:		SS#:
Relationship to Child (mother, father, parents, or other – specify):		
Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive		

Client Name: _____

Type of Custody: (Place a check next to the type of custody)					
	Both Parents Still Together		Joint Custody		Temporary Custody
	Residential Parent		Shared Parent		Other (*specify*):

Person who Child Resides with / Foster Parent / Relative Information:		
☐ *If this is the same as page 1, check this box and skip to next section.*		
Name:		
DOB:		
Street Address:		
Mailing Address:		
City:	State:	Zip:
Home #:	Work #:	Cell #:
Relationship to Child (foster parent or other – specify):		
Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive		

Biological Parent Information:
☐ *If this is the same as page 1, check this box and skip to next section.*
Biological Parent 1:
Pronouns:
Phone #:
Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive
Relationship to Child:

Biological Parent 2:
Pronouns:
Phone #:
Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive
Relationship to Child:

Person to Contact in Case of Emergency:
Name:
Pronouns:
Relationship:
Phone #:

List Names and Age of Child's Siblings and Other Persons Living in the Home:			
Full Name:	*Age:*	*Relation:*	*Sibling Lives Elsewhere? Y or N*

What is your family's gross annual income? _____

Name of Person or Agency that referred you to Child Focus:
Name:
Phone #:

Other Community and Human Service Providers Involved	Contact Name and Phone Number

Client Name: _____

(check all that apply):		
	Children's/Job and Family Services	
	Domestic Relations Court / Other Court	
	Mental Health or other Health	
	Juvenile probation	
	County DD	
	Other (specify):	

Child's Mental Health History
Has your child ever had psychological testing or counseling? ☐ Yes ☐ No
If yes, please explain:

Is your child currently on probation? ☐ Yes ☐ No If yes, explain below:

Is your child living with disabilities? ☐ Yes ☐ No If yes, explain below:
Is service animal assistance needed for a disability? ☐ Yes ☐ No If yes, what tasks is the service animal trained to perform? Explain below:

Please help us to better understand your needs and preferences:

Is your child *currently* suicidal? ☐ YES ☐ NO Is your child *currently* homicidal? ☐ YES ☐ NO

If yes, explain: _____

Do you any preferences regarding your provider?

If yes, explain: _____

Are you willing to attend appointments *earlier* than 4 p.m.? ☐ YES ☐ NO

Would you like your child to attend group treatment? ☐ YES ☐ NO ☐ UNSURE

If yes, which group? _____

Are you seeking psychiatry (e.g., medication) services? ☐ YES ☐ NO ☐ UNSURE

At this time, I prefer ☐ In person services ☐ Telehealth services (via secure video conferencing)

☐ No preference, either is fine

What is bringing you here today? Please identify your child's current needs in writing. Your service provider will review what you have written so a detailed description is most helpful in assuring your needs are met.

_____

_____

_____

_____

Client Name: _____

Severity of Current Needs:

1	2	3	4	5	6	7	8	9	10

Very little impact on functioning — Extreme impact on functioning

Please rate environmental supports for change

1	2	3	4	5	6	7	8	9	10

Very little support — Much support

Client motivation to change

1	2	3	4	5	6	7	8	9	10

Very little motivation — Very high motivation

_____ Parent / Guardian

_____ Date

Office Use Only (Clinician)

Action taken if child is suicidal/homicidal: _____

_____

_____

Office Use Only for Crisis Services and/or Diagnostic Testing (Clinician)

	ICD 10 Code	DSM V Diagnosis
Dx1		
Dx 2		

Date/Time Ongoing Appt. 1st offered	Date/Time Ongoing Appt. Scheduled	Entered into Catt
		☐ Offered ☐ Seen

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MEDICAL HISTORY

Name of Client		Date	
DOB		Age	
Name of Person Completing this form		Relation to Client	

PRIMARY CARE PHYSICIAN Check if None ☐	
Practice	
Name	
Address	
Phone #	
Date of last physical	

OTHER PHYSICIAN/MENTAL HEALTH PROVIDER Check if None ☐	
Practice	
Name	
Specialty	
Address	
Phone #	
Date of last appointment	

DENTIST Check if None ☐	
Practice	
Name	
Address	
Phone #	
Date of last cleaning	

PLEASE DESCRIBE ANY CURRENT HEALTH / MEDICAL CONCERNS FOR YOUR CHILD INCLUDING ANY CHRONIC MEDICAL CONDITIONS
Check if None ☐

HAS YOUR CHILD EVER HAD ANY HISTORY OF MEDICAL CONCERNS INCLUDING BROKEN BONES, INJURIES REQUIRING MEDICAL ATTENTION, SURGERIES OR HOSPITALIZATIONS? *IF SO, PLEASE PROVIDE DETAILS BELOW*
Check if None ☐

Client's Name: _____

CURRENT PRESCRIPTIONS MEDICATIONS *(include dose and frequency)*	PRESCRIBED BY

CURRENT OVER-THE-COUNTER MEDICATIONS *(include dose and frequency)*	CURRENT VITAMINS *(include dose and frequency)*	CURRENT SUPPLEMENTS *(e.g., Melatonin, Glucosamine, etc.) (include dose and frequency)*

PLEASE IDENTIFY ANY FAMILY MEDICAL CONCERNS INCLUDING ANY CHRONIC MEDICAL CONDITIONS
Check if None ☐

DOES YOUR CHILD CURRENTLY OR HAVE THEY EVER HAD ANY CONCERNS RELATED TO			
Concern	Present	Past	Details
Vision	☐	☐	
Hearing	☐	☐	
Speech	☐	☐	
Dental	☐	☐	
Allergies	☐	☐	
Head Injury	☐	☐	
Eating	☐	☐	
Sleeping	☐	☐	
Weight Loss or Weight Gain	☐	☐	
Dietary Needs	☐	☐	
Learning / Education Concerns	☐	☐	
Reading / Literacy	☐	☐	

HEALTH HABITS	
Are your child's vaccinations/ immunizations up to date? Please provide a copy of immunization records, if possible.	☐ Yes ☐ No Explain: *\When immunization records are not available, CFI acknowledges that the school district maintains a copy of immunization records
Is your child on a special diet?	☐ No ☐ Yes Explain:

Client's Name: _____

IS THERE ANYTHING ELSE YOU THINK WE NEED TO KNOW ABOUT YOUR CHILD'S HEALTH?

The information contained within this document is accurate and complete to the best of my knowledge. I understand that it is my responsibility, as the parent guardian, to notify Child Focus of any changes in medical history that may affect my child's treatment and/or may cause restraint to be contraindicated.

PRINT NAME OF PERSON COMPLETING FORM	RELATIONSHIP	SIGNATURE	DATE

(For office use only)

This Medical History has been reviewed by a nurse or physician. A review of the information provided by the parent/guardian ☐ does ☐ does not contain sufficient information to contraindicate use of Physical Crisis Intervention Hold (restraint).

If not contraindicated, Child Focus authorized staff may use a Physical Crisis Intervention Hold (restraint) only as a time-limited protective measure in a life-or safety-threatening situation, and only when de-escalation has failed or is not possible. A physical hold is only used until the client regains behavioral control, or until the appropriate law enforcement, safety, or other emergency service providers arrive on site, whichever is sooner. Parent/guardian is responsible for notifying Child Focus of any changes in medical history that may cause restraint to be contraindicated.

☐ I have requested the above person's health history of skin, eyes, ears and throat, respiratory system, circulatory system, endocrine system, GI, elimination, GU, neurological, musculoskeletal, surgeries and immunizations.

_____ _____

Signature Date

Diagnostic Impressions and/or Recommendations, if any:

_____

_____

_____

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Consent for Treatment

Client Name: _____ Date of Birth:_____

I give my consent for the above named client to receive services from Child Focus.

I understand that I have the right to be informed of the risks and benefits of each of the proposed services, of alternative treatments, and of no treatment.

- *Benefits* of services may include: Improvement in behavior, mood, academic performance, and/or overall functioning of child and family. *Benefits* associated with refusal of services may include: Natural resolution of the problem with little or no effort on the part of the client and/or family.
- *Risks* associated with participation in services are possible, although rare. Risks associated with services may include: Worsening of behavior, mood, academic performance, and/or overall functioning of child and family. *Risks* associated with refusal of services may include: Worsening of behavior, mood, and/or academic performance.

I understand that my consent for treatment includes permission for the exchange of mental health information with other treatment and health services providers, both within and outside of this agency. If I wish to restrict releases relating to my child's health information, I have the right to request that Child Focus limit specified disclosures of information, including disclosures for treatment information.

I understand that that in order for Child Focus to collaborate with non-treatment providers on my behalf, I will need to sign an Authorization for the Release of Information in accordance with HIPAA guidelines.

I have the right to understand the recommended course of treatment and determine which services I accept as part of my treatment. If I am not satisfied with progress in treatment, I have the right to request another service provider. I understand that I have the right to consent to, or refuse, any service at any time upon full explanation of the expected consequences of such consent or refusal.

I understand that my child's provider will review my child's symptoms to make a diagnosis, or to rule out possible diagnoses, for my child based on evidence.

I understand that I have the right to consult with independent treatment specialists at my own expense. Services for a specific treatment need may only be provided by one agency; therefore, I understand that I must choose a single agency to address each specific treatment need. My comprehensive treatment needs may be met by a single agency or multiple agencies.

I understand that I have the right to be informed (in advance) of the reason(s) for discontinuance of service provision, and to be involved in planning for the discontinuance of service provision whenever possible.

I understand that my child will not be involved in Human Research Projects without my prior written consent, except for when their de-identified data is used in aggregate form.

Only those persons with *legal custody* may provide consent for treatment.
(I have ☐ sole custody or I have ☐ shared custody of the above named child).

1. Legal guardians who are not the client's biological parent must provide proof of custody.
2. Biological parents who are not married to each other must provide court documentation of child custody agreements.
3. If you are the biological parent but do not have proof of custody, please discuss this with the registration specialist.

☐ **I give consent for the above named client to receive services from Child Focus.**

☐ **I refuse to give my consent for the above named client to receive services from Child Focus. I understand the risks associated with this refusal.**

_____ _____ _____
Parent or Guardian Signature Relationship Date

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Behavioral Health Services Orientation

Client Name: _____ Case Number: _____

If you have questions about any of the documents you receive today, please ask us!

Initials	Orientation to Child Focus Part I
	I am aware that the Client Handbook is on the Child Focus website in the "Mental Health" and then "Registration and Fees" section. I understand I may request a paper copy of this handbook at any time and this will be provided free of charge. I am aware that the Client Handbook contains: • Client Rights • Client Responsibilities • Explanation of Available Services • Agency Ethical Standards • Notice of Privacy Practices • Client Grievance Policy and Procedure
	I understand that I may be contacted by telephone or e-mail during and after services as part of Child Focus quality improvement efforts. If you do not wish to be contacted write NO in the space provided.
	I understand that Child Focus facilities are smoke-free and drug-free. Possession, use, or being under the influence of illegal drugs on agency premises is prohibited. Underage persons are not permitted to smoke or use other nicotine products, including vape, on Child Focus grounds or at agency sponsored activities at any time. Adults age 21 and over are permitted to smoke outside of the building in a designated smoking area that is out of the view of minor children. Cigarette butts are to be disposed of in a container provided at the side of the building. I understand that I need to tell staff about any medicines or medical devices I or my child use if they may affect my care or safety. This includes prescription medicine, over-the-counter medicine, vitamins, supplements, herbal products, and medical supplies. Safe Use and Storage of Medication • I understand I must keep all medicines and medical devices safe and away from children or others • I understand I will keep them with me unless staff tell me it is okay to store them somewhere else • I understand I will only use medicines as prescribed or as the label says • I understand I will throw away needles and other sharp items safely in a proper container • I understand I will not share my medicines or medical devices with anyone else Prescription Medicines • I understand I must keep prescription medicines in their original labeled containers • I understand I must keep the container closed when I am not using it
	Unauthorized weapons are prohibited on agency premises. Pursuant to ORC 2923.1214, law enforcement officers/investigators with valid identification may carry weapons they are legally authorized to possess.
	I understand that parents/guardians are expected to actively participate in their child's treatment.
	I understand it is my responsibility to notify Child Focus of any address or phone number changes.
	Medicaid recipients: I have received a Financial Responsibility Notice.
	Legal Custody: I understand that in order to initiate services I must provide proof of custody of the minor child named above. If I cannot locate the court documentation, I understand I may contact the court to gain a copy. If a copy is unavailable, please contact our office at (513)752-1555 to discuss services.
	Shared Parenting: In Shared Parenting custody situations, it is the responsibility of the registering parent to inform the other parent at the initiation of Child Focus services. Additionally, Child Focus will send a letter informing the identified other parent.

_____ _____

Parent or Guardian Name Signature Date

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Attendance Policy – Helping Families Stay Connected

Client Name: _____

To better support the youth, adults, and families we serve, Child Focus utilizes an attendance policy to keep families engaged in services and help them overcome common barriers to attending appointments consistently.

All office-based services are scheduled through our Centralized Scheduling Team to make booking and rescheduling simple and efficient for everyone. We also have a role on our team— the Engagement Specialist — who reaches out to families if a session is unattended to troubleshoot barriers and offer support.

Understanding Attendance:

We know life can be unpredictable, and sometimes appointments are missed or need to be changed. Here's how we define unattended appointments:

- **Cancelled appointments** are defined as: You let us know **24 hours** in advance that you can't attend.
- **Missed appointments:** The appointment is **unattended without notice**, **notice is less than 24 hours before, or you arrive more than 15 minutes late.**

Policy:

- For any unattended appointment, the Engagement Specialist will contact you via letter, email, and/or text.
- If, during a 90-day period, a client has:
  - **2 missed appointments, or**
  - **A total of 3 unattended appointments (missed or cancelled) within that time**

  our Engagement Specialist will attempt to contact you to discuss your situation and create a short-term scheduling plan that better fits your needs.

  During this time, routine scheduling **will pause until we reconnect** and develop this plan together.

How We'll Work With You

Once contacted, families have **10 days** to respond to the Engagement Specialist. Together, you'll develop a temporary scheduling plan, which may include:

- **Scheduling during non-peak hours**
- **Scheduling a same day appointment when available (in person or telehealth)**

Families will have **30 days** from the date of notification to complete this temporary plan. **Once you attend a session, regular scheduling will resume.** With consistent attendance, families have the ability to schedule up to four (4) recurring appointments.

Why an Engagement Specialist?

Our goal is to make services easier to access – not harder. This policy gives families **more time, flexibility, and personalized support** to stay connected to the care that matters most.

If we do not hear from you **within 10 days, or the temporary plan isn't completed within 30 days, services may be discontinued** – but our Engagement Specialist will do everything possible to help you avoid that and stay engaged.

We're Here to Help

If you have any questions or need support, please contact us at 513-752-1555. We're committed to working with you to find what works best for your family.

_____ _____

Client Signature (if age 18 or over) Date
Parent/Guardian Signature (if client is a minor)

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GOSH RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult: ☐ Yes ☐ No If yes, complete the following information.	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Client Signature	Date

Minor

Client is a Minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify):
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone number of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

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Permission to Disclose Personal Health Information to: Information System (GOSH) and Ohio Behavioral Health Information System (OBHIS)

In order for your services to be paid for--in part or in full--by the Community Mental Health, or Alcohol and Drug Addiction Services Boards, and/or Job and Family Services, and/or Medicaid it is necessary to enroll you (the client) in the GOSH and OBHIS shared database systems.

The information entered into the database is used to:

- Enroll the client in the Great Office Solution Helper (GOSH)
- Enroll the client in the Ohio Behavioral Health Information System (OBHIS)
- To determine eligibility for publicly funded services.
- To pay claims for services received.
- To report information required by the CMH/ADAMH Board and/or OhioMHAS regarding characteristics of individual seeking services and the types of services provided. The Boards and/or OMHAS use the information in aggregate form for service planning and evaluation purposes.
- To report information required by the CMH/ADAMH Board and/or the Ohio Department of Mental Health and Addiction Services (OhioMHAS) to measure effectiveness of services and evaluate treatment outcomes in my case and other similar cases.
- To report information to the CMH/ADAMH Board and OhioMHAS, as required by Ohio law, about reportable incidents that may occur while I am receiving services.

Child Focus may disclose information necessary to be paid for mental health services even if I do not authorize disclosure.

Treatment cannot be conditioned upon my signing this authorization.

I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. If not previously revoked, this authorization will expire at the time my treatment with Child Focus ends.

I understand that the information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law; however, I understand that Child Focus cannot control the use of this information once it has been disclosed.

By signing below, I am indicating that I understand all of the above. I authorize Child Focus to disclose information necessary to the Great Office Solution Helper and Ohio Behavioral Health Information System.

Client: _____ Client D.O.B.: _____

Signature of Parent/Guardian: _____

Relationship to Client: _____ Today's Date: _____

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Authorization for Release of Information for Insurance

Section I Patient Information

First Name: _____ MI:____ Last Name:_____

Date of Birth: _____ Age: _____

Section II Authorized to Disclose

I hereby authorize disclosure of health information about the above-named individual as follows:

Disclosing Entity or Person: Child Focus

Recipient(s) Receiving Entity or Person: Insurance Company (card on file)

Section III Purpose of Disclosure

Purpose of Disclosure: to provide information at my request for treatment, payment, and/or health care operations

Description of Information to be Disclosed:

☐ All Treatment Records - This allows Child Focus to submit all billable services to my insurance provider

☐ Limited Disclosure -I understand that this will limit Child Focus to submit only the chosen services to my insurance. I understand that I will be personally responsible for the fees for any services not selected.

Specify restrictions: _____

Specify time period,

☐ Release information until discharge from services

☐ Release information only from the period _____

Section IV Authorization

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing person/entity, except to the extent that action has been taken on it or if it is related to my participation in a treatment program as part of criminal justice-related proceedings. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If the recipient is a covered entity or business associate to whom a record (or information contained in a record) is disclosed for purposes of treatment, payment, or health care operations, the patient's record (or information contained in the record) may be redisclosed in accordance with the permissions contained in HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient. For other recipients, there is the potential for the records used or disclosed pursuant to this consent to be subject to redisclosure by the recipient and no longer protected.

Expiration Date or Event: ☐ Discharge from services ☐ Other Specified _____

I understand that I may refuse to sign this authorization if it is for purposes other than substance use disorder assessment, treatment or payment for that treatment. My refusal to sign it for other purposes will not affect my ability to obtain treatment, my enrollment in or eligibility for benefits, or payment provided for those services, unless conditioning of my authorization is expressly permitted under federal law.

Signature of Individual (age 12 or older)_____ Date _____

Signature of Personal Representative (if applicable) _____ Date _____

Relationship of Personal Representative _____

NOTICE TO RECIPIENTS OF SUBSTANCE USE DISORDER INFORMATION:

ODM 10221 (10/2025) 42 CFR Part 2 prohibits unauthorized disclosure of these records.

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Consent to Phone or Text Usage for Appointment Reminders and Other Healthcare Communications

Client Name: _____ Client Account Number: _____

Persons served at Child Focus may be contacted via phone or text messaging to remind you of an appointment, to obtain feedback on your experience with our service providers, and to provide general reminders/information.

_____ (*Parent/Guardian Initials*) I consent to receive phone or text messages from Child Focus at my cell phone and/or any number forwarded or transferred to that number to receive communication as stated above. I understand that this request to receive phone and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Child Focus does not charge for this service, but standard call and text messaging rates may apply as provided in your wireless carrier plan (contact your carrier for pricing plans and details).

Please choose a preferred contact method below for appointment reminders.

Choose only one:

_____ (*Parent/Guardian or over age 18 Client Initials*) I prefer to receive phone calls. I understand messages may be left on voicemail. Please use this number for reminder calls: _____

_____ (*Parent/ Guardian or over age 18 Client Initials*) I prefer to receive text messaging. The cell phone number that I authorize to receive text messages for reminder calls is: _____

_____ *(Parent/Guardian or over age 18 Client Initials).* I prefer not to receive reminder calls.

_____ _____

Parent Guardian signature
(Client if over age 18)

Date

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Child Focus Consent for Telehealth

Client Name: _____ Date of Birth:_____

I give consent for the above named client to receive **Telehealth** services at Child Focus Telehealth service is provided real-time through audio and video telecommunication technology in which the client and treating service provider are at different locations. I understand that telehealth secure videoconferencing may be used intermittently when I am unable to get to the appointment or at regularly scheduled intervals.

I understand I have the right to be informed of the risks and benefits of the proposed service, of alternative treatments, and of no treatment.

- *Benefits* of Telehealth may include: Increased access to mental health services, less wait time and distance travel required for appointments, improved care coordination with mental health providers, access to expertise from a distant specialist. There are no *Benefits* associated with refusal of Telehealth service.
- *Risks* associated with Telehealth may include: There is a small risk that equipment failure may result in broken communication with the service provider or the experience of poor video or audio quality. There is a slight risk that a delay in evaluation or treatment could result from a deficiency or equipment failure. There is a minuscule risk that security protocols could fail, causing a breach of privacy of personal health information. *Alternative Treatment*: Includes face-to-face therapy service. The *Risk* associated with refusing Telehealth service may include worsening of mental health symptoms and functioning.

I understand I have the right to be oriented to telecommunication secure video software.

I understand that federal and state laws which protect privacy and confidentiality of my medical information also apply to Telehealth. As such, I understand I will be required to verify and authenticate my child's and my own identity during sessions.

I understand that I have the right to consent to, or refuse, or withdraw my consent for Telehealth at any time upon full explanation of the expected consequences of such consent, refusal or withdraw.

I understand that I have the right to be informed (in advance) of the reason(s) for discontinuance of service provision, and to be involved in planning for the discontinuance of service provision whenever possible.

Only those persons with *legal custody* may provide consent for treatment.

(I have ☐ sole custody or I have ☐ shared custody of the above named child).

1. Legal guardians who are not the client's biological parent must provide proof of custody.
2. Biological parents who are not married to each other must provide court documentation of child custody agreements.
3. If you are the biological parent but do not have proof of custody, please discuss this with the registration specialist.

I give consent for the above named client to receive services from Child Focus

_____	_____	_____
Parent or Guardian Signature	Relationship	Date

I refuse to give my consent for the above named client to receive services from Child Focus I understand the risks associated with this refusal.

_____	_____	_____

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Telehealth Expectations

You will receive services via Telehealth. This means that you and your provider will not be in the room together, you will be connected through electronic devices over the internet.

In order for telehealth services to be most effective, we ask that you treat telehealth in the same way you would an in-office appointment to maintain the most quality experience possible. Expectations for this service include:

- Dress appropriately during telehealth sessions, as you would if you were attending a session at the office.
- Be seated on a chair or couch (sessions will not be conducted with clients or family members on a bed or floor).
- Be located in an area that is safe, has good lighting and provides privacy/confidentiality.
- Be located in a room that is appropriate. No session will be conducted with anyone participating in a bathroom.
- Have the camera on your device facing you.
- Stay in the room and remain awake, alert and engaged with the provider for the full session.
- Please do not have anyone else in the room unless it has first been discussed and agreed upon with your provider.
- Please do not conduct other activities while in session, such as driving a vehicle, shopping, engaging in recreation activities, engaging in salon activities, etc.
- Please be ready for the start of your session. Providers are on tight schedules.
- Please do not record sessions without first obtaining the provider's approval.

Failure to comply may result in the session not able to be conducted, a no show being charged, and a need for further appointments to be scheduled in the office.

I understand and will comply with the above expectations.

_____ _____

Client Parent/Guardian

_____ _____

Date Date

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Financial Responsibility Notice

- You have stated that you have Medicaid coverage.
- There is no co-pay for those clients who have Medicaid coverage.
- If you should lose Medicaid coverage for any reason, we will need to complete a fee agreement with you. In order to do so, you will need to present:
    - Proof of household income (i.e. wages, child support, disability, social security)
    - Proof of insurance, if applicable

Please notify the receptionist if you have any questions about this Notice.

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OBHIS Admissions Records Client Form

The following information is requested by OMHAS (Ohio Mental Health and Addiction Services)

Client Name _____ Date of Birth _____

Admission Type

☐ Alcohol/Other Drug ☐ Mental Health ☐ Alcohol/Drug and Mental Health

Assessment and Referral Only

☐ No ☐ Alcohol/Other Drug ☐ Mental Health ☐ Alcohol/Other Drug Alcohol/Drug and Mental Health

Paying Entity/Board: _____

Please complete this information for the registering child/adult.

Current Educational Enrollment

- ☐ K-12th Grade
- ☐ GED Classes
- ☐ College
- ☐ Other Schooling (e.g. Adult Basic, Ed; Literacy
- ☐ Vocational/Job Training
- ☐ Has not attended school in last three months
- ☐ Unknown

Education Type (If K-12 Selected)

- ☐ Has Individual Education Plan (IEP)
- ☐ Does Not Have an Individual Education Plan (IEP)
- ☐ Unknown

Highest Education Level Completed

- ☐ < 1st grade
- ☐ 1st grade
- ☐ 2nd grade
- ☐ 3rd grade
- ☐ 4th grade
- ☐ 5th grade
- ☐ 6th grade
- ☐ 7th grade
- ☐ 8th grade
- ☐ 9th grade
- ☐ 10th grade
- ☐ 11th grade
- ☐ High School Diploma/GED
- ☐ Technical School
- ☐ Some College
- ☐ 2 Yr. College/Assoc. Degree
- ☐ 4 Yr. College/Bach Degree
- ☐ Graduate Degree
- ☐ Unknown

Primary Reimbursement

- ☐ Blue Cross
- ☐ Medicaid
- ☐ Medicare
- ☐ No Charge
- ☐ Other Government Payments
- ☐ Other Health Insurance
- ☐ Other payment source
- ☐ Self-Pay

Primary Source of Income/Support

- ☐ Disability (SSI/SSD/WC)
- ☐ Family Relative
- ☐ Public Assistance
- ☐ Retirement/Pension
- ☐ Wages/Salary
- ☐ None
- ☐ Other
- ☐ Workers Compensation

Living Arrangement at Admission

- ☐ Private Residence - Adult
- ☐ Private Residence –Child
- ☐ Permanent Supportive Housing
- ☐ Residential Care/Group Home/ACF
- ☐ Community Residence
- ☐ Temporary Housing
- ☐ Foster Care
- ☐ DD Licensed/Operated Facility
- ☐ Correctional Facility
- ☐ Homeless
- ☐ Other
- ☐ Unknown

Please complete both sides of this form

Please complete this information for the registering child/adult.

Does Client Use Tobacco Products
☐ Yes ☐ No ☐ Unknown

Military Status
☐ Active
☐ Discharged
☐ Disabled Veteran
☐ None

Client County of Residence: _____

Number of arrests in the past 30 days : _____

Employment at Admission
☐ Full Time
☐ Part Time
☐ Sheltered
☐ Unemployed but actively looking for work

NOT in LABOR FORCE
☐ Disabled
☐ Engaged in Residential/Hospitalization
☐ Homemaker
☐ Inmate in Jail/Prison/Corrections
☐ Retired
☐ Student
☐ Volunteer Worker
☐ Unknown

Referred by
☐ Individual (self-referral/family/friend)
☐ Alcohol/Other Drug After-Care
☐ Mental Health Provider
☐ Other Health Provider
☐ School
☐ Employer/EAP
☐ Child Welfare (CDJFS, CSBS)
☐ Ohio Family and Children First Council
☐ Other Community Provider
☐ State Psychiatric Hospital
☐ State Prison
☐ Jail
☐ Courts/Other Criminal Justice
☐ TASC: Courts/CJ – Felony
☐ TASC: Courts/CJ – Juvenile
☐ TASC: Courts/CJ – Municipal
☐ Unknown

Number of Children in Household under 18: _____

Required for Female Clients

Childbirth in the last 5 Years
☐ Yes ☐ No ☐ Unknown

Is Client Currently Pregnant
☐ Yes ☐ No ☐ Unknown

Stage of Pregnancy
☐ First Trimester
☐ Second Trimester
☐ Third Trimester
☐ Unknown
☐ N/A

Lifetime Number of Births (live and still): _____

Please complete both sides of this form