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17 Memorial Medical Drive
Greenville, SC 29605

115 Southport Rd, Ste. F
Spartanburg, SC 29306

Phone: (864) 283 – 0637 Fax: (864) 283 – 0638

Patient Information

Patient First Name

Patient Middle Name

Patient Last Name

Personal Pronoun

Date of Birth

Social Security Number

Gender

Male | Female | Other

Explain

Race

- [ ] American Indian or Alaska Native
- [ ] Asian
- [ ] Black or African American
- [ ] Hispanic or Latino
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White

Marital Status

Email Address

Phone Number

Address

Address 2

City

State

Zip

Primary Insurance Company

Insurance ID #

Policy Holder Name

Policy Holder DOB

Insured's Relationship to the client (If Medicaid only, write "self")

Secondary Insurance Company

Secondary ID #

Policy Holder Name

Policy Holder DOB

(If the patient is a minor) Mother's Name

(If the patient is a minor) Father's Name

(If the patient is a minor) Legal Guardian's Name

Group/Facility Name

Emergency Contact Name

Phone Number

Primary Care Physician

Referral Source (Case Manager, Agency Name, Another Counselor, Social Media, Referral from friend)

Guarantor Information

Guarantor Information is responsible party information. The guarantor is always the patient unless the patient is a minor or an incapacitated adult. The guarantor for a minor child (a child that is under 18 years of age except for an emancipated minor) is the parent that presents the child for services at the time of the initial visit.

Relationship to the patient

☐ Self ☐ Parent/Guardian

Guarantor's Driver's License #

State Issued

Guarantor's Full Name

Guarantor's Date of Birth

Mailing Address (if different from patient)

Guarantor's SSN

Best Contact Number

Guarantor's Driver's License #

State Issued

Gender

Male | Female | Other

Explain

Employer

Insurance & Financial Policy (Please Read Carefully Before Signing)

I certify that I, and/or my dependent(s) have coverage with

and (if applicable)

and I assign directly to Carolina Family Services (CFS) all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. At a minimum, we are required to provide a clinical diagnosis. Some companies require additional information such as treatment plans, summaries, or copies of your entire clinical record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become a part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your private information once it has been released to them. By signing below, you allow CFS to communicate your health information for the purpose of billing and resolution of any financial difficulties posed by insurance. This consent will end when my current treatment has ended or has been terminated by Carolina Family Services.

Additionally, if you have primary/commercial insurance other than Medicaid you MUST provide us with the information. **Failure to disclose this information resulting in a denial of services, may result with your responsibility for payment.** Therefore, it is your responsibility to notify the staff of CFS regarding any and all changes to your insurance coverage.

Client/Guardian Signature

Relationship to Client

CFS Financial Assistance Program

This program is designed to provide assistance to patients and families who are experiencing financial hardships and would like to receive support from CFS. CFS hosts various events throughout the year that provide free supplies and other specific aid for food, diapers, toiletries, and school supplies.

Are you interested in enrolling in the Financial Assistance Program?

Yes | No

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Health Insurance Portability and Accountability Act (HIPAA)

All information revealed by you in a counseling or behavioral support session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form) is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below.

Use or disclosure of the following protected health information does not require your consent or authorization:

- Uses and disclosures required by law, law enforcement, judicial and administrative proceedings.
- Uses and disclosures about victims of abuse, neglect, or domestic violence.
- Uses and disclosures for health and oversight activities.
- Uses and disclosures for research purposes.
- Uses and disclosure to avert a serious threat to health or safety.
- Uses and disclosure for Workers' Compensation

PLEASE INDICATE YOUR PREFERRED METHOND OF CONTACT & HIPAA RELEASE OF INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Carolina Family Services?

☐ **Any Method of Contact (telephone, text, email)**

☐ **Limited Contact (specify):**

Select all that apply

☐ Telephone ☐ Email ☐ Text

Phone

☐ Work Phone ☐ Cell Phone ☐ Home Phone

Email

Text Number

What is the best number to leave a “confidential” voicemail or text

CFS CLIENT RIGHTS

I. As a client, you have the right to view your medical file.

II. As a client, you have the right to receive a copy of your file, but any copies will consist of documents generated by CFS only. Also, you will be charged copying fees of $ .25 per page.

III. As a client. You have the right to request amendments to your medical file.

IV. As a client, you have the right to receive a history of all disclosures of protected health information.

V. As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations, but this may result with financial obligations for any services provided.

VI. If you choose to release any protected health information you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

VII. As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

CONSENT FOR TREATMENT & PROFESSIONAL DISCLOSURE INFORMATION

I. Understanding Services: Behavioral health services are a collaborative relationship between you and your counselor, physician, and/or community support staff (CSS). Each member of this working relationship has certain responsibilities to ensure the continuity of treatment. Your counselor, physician, and/or CSS will contribute their knowledge, expertise, and clinical skills to provide support, relief and effective treatment of symptoms presented. You, as the client or family member, have the responsibility to bring an attitude of cooperation and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your dedication and motivation may increase the likelihood of a satisfactory experience and observed remission of symptoms.

Furthermore, the services at CFS are designed to help cultivate change for you, your child, and your family. Sometimes this kind of change is difficult because it raises feelings, thoughts, and worries that people try to keep inside, which can be harmful. As with any treatment, Carolina Family Services has tried to anticipate any risks you may face as a result of receiving behavioral support services, but should you have any questions regarding your risks or consent, then please discuss during your initial session. However it is important to consider that the benefits of therapy to you or your child may include improved behavior, effective communication, healthy relationships and positive mood symptoms.

II. Appointments: All office and in-home visits are by appointment only and may be scheduled with any CFS staff member. Please plan to participate in a timely manner, as missing valuable time negatively effects your treatment. If you are unable to keep a scheduled appointment, you must notify CFS at least 24 hours in advance to avoid having your case closed and treatment terminated. If you miss or cancel your appointment, it is YOUR responsibility to contact our office for a new appointment time. Please Note: Two or more missed appointments in a 6 month period will result with case closure and discharge from all CFS services.

III. Fees: We accept all South Carolina Medicaid plans. We do not accept or take money from SC Medicaid recipients, nor do we ask for or accept any co-payments. However, other clients insured outside of SC Medicaid and affiliated MCO’s will be held to the self-pay rates listed below. To aid with the cost of services, private insurance members and the uninsured, not covered by Medicaid, will be provided a Super Bill for direct reimbursement from their respective insurance company for Mental Health Services rendered. We cannot guarantee that you will receive payment as some providers do not recognize a Super Bill nor will they cover Mental health treatment services for out-of-network providers, but we will provide this service as a courtesy. However, it is the responsibility of the patient and/or the guarantor to cover any and all expenses not paid by the insurance plans and to update of any and all changes to the patient’s insurance coverage.

THERAPY

- Diagnostic Assessment = $160.00
- Follow-Up Diagnostic Assessment = $100.00
- Individual Therapy (30 min)= $50.00
- Individual Therapy (40-50 min) = $95.00
- Individual Therapy (50-60 min) = $120.00
- Family Therapies (60 min) = $120.00
- Couples Therapy (60 min) = $115.00
- CALOCUS Assessment = $150.00
- Specialized Assessments (hourly)= $100-$150

RBHS

- Behavior Modification15 min) = $20
- Family Support (15 min) = $20
- PRS (15 min) = $20
- Crisis Management (30 min) = $60
- Crisis Management (60 min) = $120
- SPD/Treatment Team Meetings (15 min) = $10

PHYSICAN/MED MGMT

- Full Medical Evaluation = $450
- Medication Management (15 min) = $40 or $160 hourly

Patient Signature (LEGAL GUARDIAN IF MINOR)

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient

Print Name

IV. Confidentiality: Communication between you and your behavioral support team (therapist, physician, and community support staff) is confidential. This means that members of your team will not discuss your case orally or in writing without your expressed written permission on a release of information (please see the following section on “Training and Supervision”). However, all staff at CFS have an ethical and legal obligation to break confidentiality under the following circumstances:

1. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
2. Observed environmental dangers impacting safety of client, child or other vulnerable family members.
3. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit or have intent to commit.
4. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
5. If you introduce your emotional condition into a legal proceeding or it is introduced by another Agency that requires professional recommendations or knowledge.
6. If there is a court order or subpoena requesting immediate release of your records.

V. Confidentiality & Children: To ensure security and trust, child and adolescent clients must feel they are able to speak freely without consequence of disclosure to their parents or authorities. Thus, all services provided to children above the age of 12 are strictly confidential.

1. For teenagers ages 12 to 19, all discussions between any behavioral health specialist and client are confidential. However, CFS staff will disclose information to parents if: 1) the child is at serious risk of harming self or others; and 2) the child is involved in potentially self-destructive behavior like heavy drug use or unprotected sex; 3) there exist situations that may severely hamper treatment. In the latter case, CFS may choose not to share the specifics of the information but may refuse to continue the case if the child will not self-disclose. Many times the therapist will use information shared by the child to guide and direct the parent(s) toward more effective parenting. However, CFS will not routinely disclose to parents issues of minor drug use, protected and safe sex practices, issues relating to sexual preference or gender expression, legal infractions, or violations of house rules that are unbeknownst to the parents.2. Teens should be aware that parents could file court action to open their records. However, CFS discourages this practice and reserves the right to decline services for parents who will not consent to allow the therapist to disclose only what is necessary to further their progress. To be clear, therapy cannot be effective if children believe the therapist is an information conduit to their parents. If parents wish to discuss this matter with the therapist, they are encouraged to do so before any individual time is scheduled with the child.3. Records for children may be requested by a family member, legal guardian, physician or any other outside agency; however, CFS reserves the right to refuse record dissemination to ANY individual with a pending or founded case of abuse and neglect. In the event release of these records may result in harm to the client or other family member, records will be refused and required to adhere to a subpoena before release.

VI. Training & Clinical Supervision: Carolina Family Services is a training center for Bachelor’s, Master’s and Doctoral level counseling interns, licensed associates, and other paraprofessional supports. All behavioral support staff are under the supervision of licensed mental health professionals and supervisors. As such, they are required to attend weekly to monthly supervision and staff meetings where your case may be discussed and private information may be revealed. In order to ensure that counselors receive the best possible training, and that clients are well served, your sessions may be video or audiotaped. Tapes are reviewed in supervision and are always erased in a timely manner. Additionally, you must agree that your case can be discussed in supervision to receive services at CFS, as this is a SC licensure and Medicaid requirement.

All of our therapists are licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage, and Family Therapists, and Psycho-educational Specialists. This Board is located in The Synergy Center (Kingstree Building) in Columbia, South Carolina at 803- 896-4652 (mailing address is P.O. Box 11329 Columbia, SC 29211-1329). Additionally, all of our therapists abide by the American Counseling Association Code of Ethics. We employ a variety of therapists with a range of experiences and expertise. During your first session with your therapist, they will provide you with a statement detailing their education, training, licensure limits, and clinical experiences. Additionally, they are responsible to provide their professional disclosure statement, which should entail their licensure status and supervisor information. In the event that you have a problem with the therapist or services rendered to your child, please contact our Clinical Director, Tamara Siders (Tamara@CarolinaFamily.org) or the Executive Director, Jennifer Brooks (jennifer@carolinafamily.org).

VII. Contact Information: CFS has two physical locations: 17 Memorial Medical Drive Greenville, SC 29605 (Primary mailing address) and 115 F Southport Road Spartanburg SC 29303. Our office hours are Monday-Thursday 8:30am-7:00pm; Friday 9am-1pm in our Greenville location, and Monday-Thursday, 8:30am-8:00pn in our Spartanburg location, but we can also be reached at each of our locations by calling our main line at (864) 283-0637. If we missed your call or you are contacting us outside of our designated hours, you may leave a confidential voicemail. Any calls placed on Friday or over the weekend are returned when normal hours resume on Monday. Our email

address is info@carolinafamily.org, and it is checked at least once every day. Our website is www.carolinafamily.org and contains more information regarding Carolina Family Services, and all of the services that we provide. Additionally, you can fax information to us at (864) 283-0638.

VIII. Emergency & Crisis Services: Counselors and therapists check for voice mail and email messages during normal business hours, but crisis services are not provided. Messages left outside of normal CFS hours of operation will be picked up on the next business day. If you have an emergency that needs immediate attention, you may need to seek assistance at the nearest emergency services department or call local law enforcement. However, RBHS and community support specialists are available 24-7 for deemed emergencies. Information regarding their personal contact will be provided during your initial intake appointment in the home. In the event you cannot reach your in-home specialist, please contact our Executive Director, Jennifer Brooks (Jennifer@carolinafamily.org).

IX. Medication Management: It is the policy of CFS to maintain a safe and competent medication management system that is based on best practice and the care process of all clients that includes: recognition of the problem/need, assessment, diagnosis(es), medication administration, management, monitoring and revising the individualized, person-centered approach to care as well as documentation consistent with standards of medication management and administration standards. Due to this, all clients who receive medication management are required to participate in core services and/or community support services. Successfully discharged clients may maintain medication management when a bridge appointment to a PCP is unavailable.

All medication refill requests should be addressed at the time of your visit with the physician. If there are extenuating circumstances, you may call the office to contact your physician about a medication refill request. However, all refill requests should be processed during the time of your appointment. It is YOUR RESPONSIBILITY to inform us at least 14 days before your child will be out of medication. Failure to provide the physician and staff of CFS at least 14 days may result with lapses in treatment due to limited availability of our Physician. If you need any further assistance, please call our offices at 864-283-0637. Please be aware that any prescription refills will need to be picked up at the CFS Greenville office during normal business hours. This applies to both controlled and uncontrolled medications.

X. Records: CFS handles the release and/or disclosure of all confidential patient medical records in a manner that strictly adheres to state and federal laws, rules and regulations. Original medical records are the property of the CFS, and as such will not be released from our Agency unless in accordance with a court order, subpoena, or due to direct request with a release of information. Original medical records are never allowed to leave our Agency without prior authorization and approval by the treating provider(s) or his or her designee. Therefore, we require 5-7 business days to process records requests unless deemed an emergency. All expedited requests will need to be directed to our records department with a specific request to shantel@carolinafamily.org.

XI. Terminating Treatment: You have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

CFS reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by CFS of your therapeutic needs, CFS's ability to address those needs, or other circumstances that lead CFS to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, CFS will suggest an appropriate counselor(s) or counseling agency and make necessary referrals for continuity of care. Since we have provisionally licensed or dually employed staff, some behavioral health support staff are generally contracted with CFS. Therefore, it is possible that your staff may leave CFS prior to discharge of treatment. If this occurs, we will take reasonable steps to ensure a smooth transition and to provide an appropriate transition within our Agency. In the event we cannot continue behavioral health services, we will ensure referrals to appropriate Agencies, but it is your responsibility to seek out such treatment.

XII. Telehealth Treatment & Consent (Updated 2020-due to COVID-19): Telehealth is providing therapy and other behavioral health services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged. As with any medical procedure, there may be potential risks associated with the use of Telehealth. Risks with these services consist of the following:

1. Therapy conducted online is technical in nature and problems may occasionally occur with Internet connectivity difficulties. Service interruptions are outside of the control of CFS.
2. Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
3. Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment.
4. Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
5. A lack of access to all of the information that might be available in a face to face visit, but not in a Telehealth session, may result in errors in provider judgment.

XIII. Client Rights & Responsibilities for use of Telehealth

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telehealth services.
- I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical

information.

- I have the right to withhold or withdraw my consent to the use of Telehealth during the course of my care at any time.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of Telehealth during the course of my care at any time.
- I understand that all the rules and regulations, which apply to the practice of medicine in the state of South Carolina also apply here.
- I understand that the provider will not record any of our Telehealth sessions without notification and consent, but that these may be used during supervision and treatment team staffings.
- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I will not record any Telehealth sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
- I have read and understand all of the policies of CFS, and that they apply to all telemedicine as well as all in-person visits.

XIV. Other Policies & Procedures

Supervising Children: Children under the age of 18 MUST be supervised at ALL times by a parent, guardian or agency representative. Carolina Family Services' Staff and its entities are not responsible for the safety, care, supervision or entertainment of ANY child left unattended, including patients. While we understand that parent participation is important in therapy, it is YOUR responsibility to ensure childcare for children who accompany patients to Carolina Family Services. In addition, at no time, should a child be left in the lobby while a guardian leaves the building or its facilities. Failure to respect or abide by this policy may result in immediate termination and discharge from Carolina Family Services.

Freedom of Choice: I have been informed and provided with alternative options for services available to my child, family, or my self. I understand I have a right to choose the provider of these services, and I have been given the opportunity to choose between enrolled Medicaid providers in the community either by my referring agent or on my own volition. I have selected, Carolina Family Services, to provide services offered, to include core therapies, physician services and RBHS treatment. As long as I remain eligible for ANY behavior health services, I will continue to have the opportunity to choose between qualified Medicaid providers, and I have the right to terminate with CFS at any time by writing or verbal notification. I also understand that I have the right to refuse behavioral health services, and this refusal does not prevent me from receiving other Medicaid services for which I may qualify with other agencies.

COVID-19: The current pandemic has impacted how we operate safely and perform usual job duties. Therefore, CFS and its staff have implemented safety protocols and standards that must be adhered to at all times to maintain treatment. Effective immediately, all staff and patients will submit to daily temperature checks prior to entering CFS buildings. In-home staff will use PPE's and maintain appropriate social distancing standards when applicable. All patients and family members are required to wear a mask unless they have a condition preventing the use of such masks and equipment. Additionally, minor patients may be accompanied by no more than 2 family members, who agree to adhere to a temperature check and the use of a face mask or shield before entering the building. In the event safety protocols cannot be adhered to, patients and their families can convert services to Telehealth while these are available. Complete refusal to adhere to COVID-19 protocols will result with case closure and a referral to an outside Agency.

I HAVE READ THIS CONSENT & PROFESSIONAL DISCLOSURE AND UNDERSTAND IT ENTIRELY.

I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED REGARDING ALL BEHAVIORAL HEALTH SERVICES, TO INCLUDE TELEHEALTH, AND I GIVE MY INFORMED CONSENT TO ALL OF THESE SERVICES. I HAVE READ AND UNDERSTAND ALL THE INFORMATION PROVIDED IN THE PRECEEDING PAGES REGARDING CONFIDENTIALITY AND SUPERVISION, AND I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS TO MY SATISFACTION. I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature (Legal Guardian If The Patient Is A Minor)

Date

Relationship to Patient

Print Name

In treatment, we often see family members and other supporting adults who wish to participate. Please list all other participants who agree and may be involved with in any treatment services with CFS. By listing their name below, you have agreed to allow the discussion of protected health information in sessions, and you have informed those participants of any imposed or actual risks they may experience from treatment involvement:

Additional Consenting Participants (Please list ALL possible members):

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Authorization to Disclose/Release Health Information

For Office Use Only

Patient First Name **Patient Middle Name** **Patient Last Name** **Nickname**

Address **Address 2** **City** **State** **Zip**

Phone **Social Security Number**

Gender

Male Female Other

Explain

Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White

Date of Birth

MY AUTHORIZATION:

I request and authorize the release of information FROM the following (Please include relatives who may be involved in clinical treatment):

I give permission for Carolina Family Services to release records TO the following (Please include relatives who may be involved in clinical treatment):

What I AUTHORIZE TO BE DISCLOSED (Please Check All That Apply):

- Assessment and Evaluations (Diagnostic, Follow-up, CALOCUS, Psychiatric)
- Clinical Service Notes-Therapy
- Psychiatric Medication Management Notes
- Treatment Plans of Care
- Screening Assessments/Measures Used
- Treatment Progress Summaries
- Letters of Recommendation
- Discharge Summary/Termination of Service Information

Please Note: This includes specific permission to release the following:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, but not limited to:

- Psychological, psychiatric or other mental impairment(s) (excludes “psychotherapy notes” unless otherwise requested or subpoenaed).
- Drug abuse, alcoholism, or other substance abuse
- Medical diagnoses, self-disclosures about medical history, or past diagnostic information.
- Sickle Cell Anemia

- Human Immunodeficiency Virus (HIV) infection, including Acquired ImmunoDeficiency Syndrome (AIDS) or tests for HIV or sexually-transmitted disease.

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affects my ability to work.

3. Copies of education tests or evaluations, including individualized education programs, assessments, psychological and speech evaluations, teacher observations and evaluations, and any other records that can help evaluate my or my child's functional level.

4. Information created after this authorization is signed, as well as past information that may be pertinent to requested release.

I UNDERSTAND THAT:

- I understand that I have the right to revoke this authorization, in writing, at anytime.
- There are some circumstances where the information may be disclosed to other parties involved for the purpose of billing or by subpoena.
- I may receive a copy of this form upon request.
- I may ask the source to allow me to inspect or get a copy of the material to be disclosed by Carolina Family Services of Greenville prior to authorized disclosure.

PLEASE NOTE: Randomly selected records are read by licensing personnel, insurance auditors and peer reviewers for accrediting bodies. Detailed information, including name, age, mental health diagnoses, and reasons for admission, purpose of treatment, etc, may also be reported or disclosed to South Carolina Department of Health and Human Services. If you are concerned that your information will be disclosed or want to know if your information has been disclosed, then you have the right to request this information.

Patient/ Client Signature

Legal Guardian Signature (if under 18)

Patient/ Client First Name

Legal Guardian Name

Patient/Client Last Name

Relationship

For Office Use Only (CFS Staff only)

Click to Sign

Office Staff Signature (For Office Use Only)

Office Staff Name

Relationship/Position

4

Uploads

Commercial or Medicaid insurance

Secondary Insurance

Upload Patient's SS Card (If not uploaded, please bring the card with you to first appointment)

Upload Driver's License

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Is the client between the ages of 6-17? Yes No

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Full Name **Age**

Relationship with the child **Sex** Male Female

Instructions (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past **TWO (2) WEEKS.**

During the past TWO (2) WEEKS, how much (or how often) has your child…

1. Complained of stomachaches, headaches, or other aches and pains? **Highest Domain Score (clinician)**
0 (None) 1 (Slight) 2 (Mild) 3 (Moderate) 4 (Severe)

2. Said he/she was worried about his/her health or about getting sick? **Highest Domain Score (clinician)**
0 (None) 1 (Slight) 2 (Mild) 3 (Moderate) 4 (Severe)

3. Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? **Highest Domain Score (clinician)**
0 (None) 1 (Slight) 2 (Mild) 3 (Moderate) 4 (Severe)

4. Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? **Highest Domain Score (clinician)**
0 (None) 1 (Slight) 2 (Mild) 3 (Moderate) 4 (Severe)

5. Had less fun doing things than he/she used to? **Highest Domain Score (clinician)**
0 (None) 1 (Slight) 2 (Mild) 3 (Moderate) 4 (Severe)

6. Seemed sad or depressed for several hours?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

7. Seemed more irritated or easily annoyed than usual?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

8. Seemed angry or lost his/her temper?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

9. Started lots more projects than usual or did more risky things than usual?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

10. Slept less than usual for him/her, but still had lots of energy?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

11. Said he/she felt nervous, anxious, or scared?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

12. Not been able to stop worrying?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

13. Said he/she couldn’t do things he/she wanted to or should have done, because they made him/her feel nervous?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

14. Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

15. Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

16. Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

17. Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

Highest Domain Score (clinician)

18. Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?

Highest Domain Score (clinician) _____

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

19. Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?

Highest Domain Score (clinician) _____

☐ 0 (None) ☐ 1 (Slight) ☐ 2 (Mild) ☐ 3 (Moderate) ☐ 4 (Severe)

In the past TWO (2) WEEKS, has your child …

20. Had an alcoholic beverage (beer, wine, liquor, etc.)?

Highest Domain Score (clinician) _____

Yes | No | Don't Know

21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?

Highest Domain Score (clinician) _____

Yes | No | Don't Know

22. Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?

Highest Domain Score (clinician) _____

Yes | No | Don't Know

23. Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?

Highest Domain Score (clinician) _____

Yes | No | Don't Know

24. In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?

Highest Domain Score (clinician) _____

Yes | No | Don't Know

25. Has he/she EVER tried to kill himself/herself?

Highest Domain Score (clinician) _____

Yes | No | Don't Know