WVU Medicine Behavioral Health Psychology
2004 Professional Court
Martinsburg, WV 25401
Phone: (304) 596-5780 opt 3 Fax: (304) 596-5781
uhpbehavioralhealth@wvumedicine.org

WVU Medicine Behavioral Health Psychiatry
2010 Doctor Oates Drive, Suite 105
Martinsburg, WV 25401
Phone: (304) 596-5780 opt 4 Fax: (304) 596-5781
uhpbehavioralhealth@wvumedicine.org

Patient Name: _____ **Date of Birth:** _____
Caregiver Name(s) : _____
Contact Number: _____ _____
Address: _____

OFFICE POLICIES

1. Required for All Appointments - At each visit you must bring your current insurance card, photo identification, and a method of payment. We accept cash, check, credit/debit cards. Failure to provide your insurance card with co-pay or payment in full (if no insurance) may result in your appointment being rescheduled. Additionally, please notify our staff of any address or insurance changes before your appointment.
2. Payment for Services - Payment for services rendered is required at the time of the visit.
3. Insurance - We have made prior arrangements with many insurers and health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. **In the event your health plan determines a service to be "NOT COVERED," you will be responsible for the complete charge**. In that event, we will bill you and payment is due upon receipt of that statement.
4. Emergencies - **Our office does not provide "emergency services."** If the patient during his/her treatment has an urgent concern, an appointment will be scheduled as soon as possible.
    a. The Child Mobile Crisis Team provides 24/7 support at 304-596-2110.
    b. If the patient has a critical emergency, we recommend that patients present to their nearest emergency department or call 911.
    c. After Hour Calls - The office has an answering service that you may leave a message with after office hours. They will page the provider, if indicated. The provider will then provide recommendations through the answering service.
5. Cancellation Policy - Please notify our office **24 hours in advance** if an appointment will be missed. **Failure to show up for two appointments without notification or repeated late cancellations are grounds for termination of services and referral.**
6. Prescription refill - Please contact your pharmacist to request maintenance medication refills. If you do not have additional refills authorized, the pharmacy will need to fax a refill request to our office for approval. **Call your pharmacist at least five (5) business days ahead** of the need for a refill. There will be no refills approved on weekends or holidays.
    a. Controlled medications - **Physicians will not re-write any controlled medications before it is time for them to be filled again.** It is your responsibility to maintain safeguard of your prescriptions once you leave the office. We will not make any exceptions.
7. Documents/Forms to be filled out - Please allow at least **ten (10) days** for any documents/forms, etc. to be completed by the provider. If an address or fax number is provided to us as to where it needs sent, we will mail or fax the forms for you. Otherwise, we will call you when they are finished and ready to be picked up.

Patient Agreement

I have read the office policies and agree to abide by them. I, the undersigned, hereby authorize examination and any other medical services deemed necessary by the healthcare providers of WVU Medicine: Behavioral Medicine and Psychiatry. I authorize my healthcare providers to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. I, the undersigned, authorize payment of medical benefits for services rendered to me. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize release of information acquired in the course of my examination and treatment to any other healthcare provider(s) involved in my care.

Medicare Authorization

I, the undersigned, authorize the healthcare provider to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed to determine benefits payable for related services. I authorize the same information to be sent to my secondary insurance carrier. I authorize the payment of Medicare benefits to WVU MEDICINE Behavioral Medicine and Psychiatry for any services furnished to me.

Signature of patient or legal guardian: _____**Date:** _____

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Child and Adolescent for Psychological or Psychiatric Services

CONFIDENTIAL

Patient's Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Preferred pronouns: _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INFORMATION. THIS WILL HELP US MATCH YOUR CHILD WITH THE APPROPRIATE PROVIDER TO MEET HIS/ HER/ THEIR NEEDS.

Why are you seeking help?

Current Symptoms Checklist:

( ) Sleep	( ) Socially withdrawn	( ) Repetitive behaviors	( ) Delayed Development
( ) More irritable/ cranky	( ) Excessive worry	( ) Anxiety Attacks	( ) Depressed Mood
( ) Trauma	( ) Excessive Energy	( ) Concentration/forgetfulness	( ) Impulsivity
( ) Defiance	( ) Aggression	( ) Outbursts/ Tantrums	( ) Hallucinations

I would like for my child to receive the following (circle all that apply):
ADHD EVALUATION AUTISM EVALUATION EVALUATION: _____
THERAPY MEDICATION EVALUATION I DON'T KNOW

Primary Caregiver's Name: _____ Relationship to Child: _____
Second Primary Caregiver's Name: _____ Relationship to Child: _____

Legal custody of children*: _____ Physical custody of children: _____

School: _____

***If there is a custody agreement, please attach documentation verifying legal custody.**

Medical History

Please check any that apply to your child:

□ Seizures or epilepsy
□ Cancer/ Tumor
□ Other neurological condition (e.g., Spina Bifida)
If yes, please list: _____
□ Brain injury
□ Genetic Disorder (e.g., PKU, Fragile X)
□ Other chronic medical condition
If yes, please list: _____

Developmental History

Please check any that apply to your child:

□ Met all developmental milestones on time
□ Speech delay
□ Premature birth
□ Other developmental delays
If yes, please list: _____

Did your child receive services through Birth-to-Three? ( ) Yes ( ) No

Please check any that apply to your child.

□ Special education services/ Individualized Education Plan
□ 504 Plan
□ Speech and Language Therapy in school
□ Occupational Therapy in school
□ Other services: _____