Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

CHILD INTAKE PACKET

Welcome to Provident Behavioral Health! Please complete the attached forms to begin services with our team of behavioral health professionals.

You have been scheduled with: _____

Clinician Name & Credentials

_____

Crisis Services

At Provident, you have access to a team of crisis workers 24/7/365. During regular office hours, please call the office where you receive services and ask to speak to your provider if you are in crisis or need immediate assistance. If available, a member of your treatment team will speak with you and assist you. Should your provider be unavailable, another staff will assist you or you will be linked with a Provident Crisis Worker.

After-Hours Crisis Calls for Child Clients: Please call **314-446-2874** for Provident's Crisis Workers for support at any time. Services are available 24 hours a day. In the event that the nature of the emergency is such that you require immediate attention, please call 988 for the National Suicide Prevention Lifeline, call 911, or go to the emergency room nearest you.

Consent to Treatment

- I have chosen to receive behavioral health services from Provident. Services include, but are not limited to, Psychiatric Evaluation, Mental Health Assessment, Medication Management, Case Management, Psychoeducation, and Individual, Family, and Group Therapies.
- I understand that there are both risks and benefits associated with treatment, including side effects from medications that are prescribed.
- I understand that treatment may deal with painful or problematic emotions and experiences. Discussing these experiences may be uncomfortable. However, avoiding the feelings prolongs the discomfort that already exists. During treatment, painful emotions may become more intense, which can be a sign that desired changes are about to occur. I agree to discuss any and all noticeable differences with my child's treatment team.
- I understand that participation in therapy requires an openness and honesty between the therapist and my child. I understand that confidentiality is essential to children experiencing difficulties. I understand that confidentiality is extended to children in treatment and that only under certain circumstances is confidentiality broken.
- I understand that treatment is a collaborative process and progress depends on willingness to actively participate in the change process. I understand that my participation and support of treatment is related to the benefits my child will receive.
- I understand there is no guarantee that progress will occur.
- I have the right to be informed about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the clinician's qualifications, credentials, and relevant experience; continuation of services if the clinician is unable to continue providing treatment; and other pertinent information.
- I understand that there are fees associated with services and that inability to pay these fees may interrupt the course of treatment.
- I understand that I may stop treatment at any time. I will be responsible for payment of services myself or my child has received. I understand that there may be consequences to ending treatment, such as when treatment is court ordered.
- I understand that Provident may terminate treatment if the needs of myself or my child cannot be met by the agency. I understand that agency staff will refer me to an appropriate alternate provider should this occur.
- I understand that I or my child may not be allowed to continue participating in treatment if I or my child: engage in acts of physical violence or verbal abuse; possess a weapon; are under the influence of alcohol or drugs; or engage in illegal behavior on Provident premises.
- I understand that my child's right for informed consent may be waived in the event that my child is at risk of harm to himself/herself or others and professional intervention is necessary.
- I understand that a surrogate decision maker may provide informed consent on my child's behalf in the event that I and/or my child is in the event that a physician, psychiatrist, and one other mental health professional determine that I and/or my child has lost the capacity to make informed decisions. A surrogate decision maker can only consent to specific mental health services permitted by the Mental Health and Developmental Disabilities Code.
- I understand that my clinician may ask if I consent to the use of AI (artificial intelligence) tools to generate meeting summaries that assist with documentation. Please note that sessions are not recorded, and any AI-generated summaries are deleted promptly after use. All sessions are conducted via HIPAA-compliant Zoom, and confidentiality and data security are maintained in accordance with HIPAA standards. I understand I have the right to decline or withdraw consent for AI-assisted documentation at any time during services without affecting my care.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Client Rights and Responsibilities

As a Provident client, you are entitled to the following **rights**:

- To be treated with respect, consideration, and dignity, including consideration of social, psychological, spiritual and cultural needs without discrimination including race, color, religion, sex, age, national origin, disability, veteran status, gender identity, gender expression, sexual orientation (real or perceived), or any other characteristic protected by applicable United States federal or state law.
- To be informed about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the clinician's qualifications, credentials, and relevant experience; continuation of services if the clinician is unable to continue providing treatment; and other pertinent information.
- To be treated by professionals who uphold the highest ethical standards and to receive services in a safe, clean environment.
- To participate in decisions involving your treatment and suggest changes to treatment.
- To involve family members and other significant others in your treatment and decision making.
- To be informed about the limits of privacy and confidentiality, and to approve or refuse the release of your treatment records, except when release is required by law.
- To receive information concerning your diagnosis, treatment, and prognosis; and to accept or refuse treatment after full information is given.
- To know what services are available within Provident and the availability of after-hours and emergency coverage.
- To be referred to other professionals when additional services not available through Provident are needed or resources outside of Provident can more appropriately serve my needs.
- To be informed of any change in provider providing my services during treatment.
- To be assisted in obtaining an interpreter in cases of communication barriers (for example, language or hearing impairment)
- To be assisted in obtaining an advocate to represent you when appropriate.
- To have assistance in accessing protective services in instances of abuse or neglect.
- To access a copy of your medical record and request amendments, when appropriate.
- To know the fee for services provided, the policies regarding payment of fees, and to be informed when fees change.
- To discuss dissatisfaction with services provided with your provider by filing a grievance and by participating in the complaint resolution process. Formal grievances are to be submitted in writing to the supervisor at the office at which you receive services or to Department Leadership. Department Leadership will speak with the client and investigate on behalf of the griever, if necessary. A written statement of results will be given to the griever/client within five business days and will include: date grievance received, summary of grievance, overview of investigation process, timetable for completing investigation and notification of resolutions. You can contact the Vice President of Programs at 314-371-6500. Furthermore, you can contact **The Joint Commission** (800-994-6610 or complaint@jointcommission.org) to report any concerns or register complaints about Provident.

As a Provident client, you have the following **responsibilities**:

- To provide, to the best of your knowledge, accurate and complete information about present concerns, past treatment, hospitalizations, medications, and other matters relating to both your physical and mental health.
- To follow the treatment plan developed with your provider and to be responsible for the consequences of refusing treatment or not complying with treatment recommendations.
- To ask questions when you do not understand treatment recommendations or services that are recommended to you or what is expected of you as a client.
- To share your expectations of Provident and to provide feedback on your satisfaction with services received.
- To pay the established fees for services provided at the time services are rendered.
- To attend your appointments and, when unable to do so, to notify the office at least 24 hours in advance.
- To provide current information regarding any insurances you have as well as any changes in insurance coverage that occur during the course of treatment at Provident.
- To follow Provident's Policies and Procedures
- To be considerate and respectful of Provident clients, staff, and property.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Subpoena Policy

The role of Provident staff is to provide behavioral health treatment and support for our clients and their families. It is not our role to go to court, to be an expert witness, or to make custodial or other legal decisions on behalf of our clients. In the event that a Provident employee is subpoenaed regarding your treatment, you will be responsible for all fees incurred, including but not limited to: time reviewing and compiling your medical records, time spent writing reports or treatment summaries, travel time to and from court, and time spent waiting in court and on the stand. **The fee for services provided in response to subpoenas is $150.00 per hour and must be paid out of pocket by the client, client's parent or guardian, or legal counsel.** As always, we are happy to provide any documentation regarding your treatment in writing once you have signed a Release of Information allowing us to do so.

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction: Provident has adopted this Privacy Practice Policy to comply with the Health Insurance Portability and Accountability Act (HIPAA, 1996), the Health Information Technology for Economic and Clinical Health Act (HITECH, 2009), the Omnibus Rule (2013), and the Department of Health and Human Services (DHHS) security and privacy regulations, as well as to fulfill our duty to protect the integrity, confidentiality, and availability of confidential medical information as required by law, professional ethics, and accreditation requirements. All personnel of Provident Behavioral Health (Provident) must comply with this policy. Familiarity with this policy and demonstrated competence in the requirements of the policy are an important part of every employee's responsibilities.

Assumptions: This Notice of Privacy Practice Policy is based on the following assumptions:

- Individually identifiable health information or protected health information (PHI) is sensitive and confidential. Such information is protected by law, professional ethics, and health care accreditation requirements.
- HIPAA requires Provident to protect PHI and to ensure that Provident's Business Associates also protect PHI.
- Provident must enter into Business Associate contracts to protect PHI.
- A Business Associate shall have the meaning specified in the HIPAA Privacy Rule, HIPAA Security Rule, the HITECH Act, and the Omnibus Rule.
- Provident can best perform its duties through the adoption and enforcement of a Privacy Practice Policy.
- Provident workforce members and Business Associates are all bound by this policy, including, but not limited to, any individual who is involved with Provident for the following purposes: employees, volunteers, billing, practicum/internship, and other roles and relationships where access to PHI & ePHI is required.

Provident, its Workforce Members, and Business Associates will:

- Collect, use, and disclose individual medical information only as authorized. Provident's workforce members and Business Associates will not use or supply such information for any purpose other than those expressly authorized by law, professional ethics, and accreditation requirements.
- Implement administrative, physical, and technical safeguards to protect PHI from unauthorized access or disclosures.
- Ensure that medical information must be accurate, timely, complete, and ensure that authorized personnel can access this data when needed.
- Not alter or destroy an entry in a record, but rather designate it as an error while leaving the original entry intact and create and maintain a new entry showing the correct data.
- Implement reasonable measures to protect the integrity of all data.
- Recognize that our clients have a right of privacy and respect clients' individual dignity at all times. Privacy will be respected to the extent that is consistent with performing required services and with the efficient administration of our business.
- Act as responsible information stewards and treat all individual PHI (including medical record data and related financial, demographic, and lifestyle information) as sensitive and confidential.
- Use or disclose only the "minimum necessary" health information to accomplish the particular task for which the information is used or disclosed.
- Disclose information only when there is written authorization for uses or disclosures of psychotherapy notes (if psychotherapy notes are maintained), for uses or disclosures for marketing purpose, and for uses and disclosures that involve the sale of Protected Health Information.
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.
- Not divulge PHI unless the client (or his/her authorized representative) has properly consented to the release or the release is otherwise authorized by law.
- When releasing PHI, take appropriate steps to prevent unauthorized re-disclosures, such as specifying that the recipient may not further disclose the information without client consent or as authorized by law.
- Implement reasonable measures to protect the confidentiality of medical and other information.
- Recognize that some medical information is particularly sensitive, such as HIV/AIDS information, mental health and developmental disability information, alcohol and drug abuse information, and other information about sexually transmitted or communicable diseases and that disclosure of such information could severely harm clients, such as by causing loss of employment opportunities and insurance coverage, as well as the pain of social stigma.
- Treat particularly sensitive information with additional confidentiality protections as required by law.
- Recognize that the client has a right of access to information contained in the medical record owned by Provident.
- Permit clients to access and copy their PHI in accordance with the requirements of the privacy regulation, including their electronic medical record and hard-copy medical record.
- Provide clients an opportunity to request correction of inaccurate data in their medical records in accordance with the requirements of the privacy regulation.
- Allow clients to restrict disclosures of PHI to a health plan when the individual pays out of pocket in full for services received.
- Document and provide clients an accounting of uses and disclosures other than those for treatment, payment, and health care operations in accordance with the requirements of the privacy regulation. Breaches of confidentiality will be documented via Incident Report forms.
- Verify that uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the client.
- Provident will inform you if a breach occurs that may have compromised the privacy or security of your information.

Enforcement: All employees, volunteers, and Business Associates of Provident must adhere to this policy. Provident will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment, professional discipline, and criminal prosecution, in accordance with Provident sanction policy and personnel rules and regulations.

Access to Records Under the Cures Act: In accordance with the 21st Century Cures Act, clients have the right to access their electronic health records through a secure online patient portal. This includes clinical notes and other finalized health information. Progress Notes will be available for viewing in your ClinicTracker Patient Portal as they are completed, ensuring transparency and timely access to your care information. If you require official copies of your records or wish to have them sent to a third party, a signed Release of Information (ROI) form will be required. Please note that fees may apply for processing and delivery of official records.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Statement of Confidentiality

As a client at Provident, we want you to be informed of your rights and the limits of confidentiality. The confidentiality of personal information shared with your provider(s) is the cornerstone of a therapeutic relationship. In most circumstances, information shared is considered privileged communication and will not be shared with anyone, unless the client first provides signed written consent to do so.

There are, however, some limitations of confidentiality which require the disclosure of information. These include, but are not limited to, the following:

- When there is a serious threat of physical harm to yourself or another person (e.g., suicide or homicide);
- When mandated by state or federal law (e.g., in cases of known or suspected physical or sexual abuse or neglect of children, the elderly, or developmentally disabled);
- When specifically ordered by a court of law;
- For the purpose of professional supervision. Cases at Provident are reviewed regularly with a Clinical Supervisor to ensure quality of the care you are receiving;
- When collaborating with or consulting with your treatment team, including but not limited to: case managers, clinicians, psychiatric mental health nurse practitioners, medical assistants, collaborating psychiatrists, supervisors, practicum students/interns, and others that are Provident clinical and administrative workforce members involved in your treatment program. These individuals are bound by confidentiality requirements. A Release of Information is required to share information with individuals outside of your treatment team at Provident;
- When services are provided out in the community where confidential space is not available or interventions are conducted in public settings, such as in school settings or community based programs. In such circumstances, it may be possible for confidential information to be overheard or clients to be seen by others present in the setting. Please note that Provident staff are to exercise discretion to limit and prevent confidential client information from being disclosed in these settings.
- Information gathered from questionnaires, assessments, and surveys that are used for the purpose of data collection, outcome measurement, or research. Please note that any identifying information will be removed from data used;
- The use of insurance or third-party funding source implies consent by the client that information regarding diagnosis, treatment plan, and clinical information may be disclosed to your insurance company or funding source in order to facilitate insurance claim filing or management of care with your insurance or managed care company.
- Progress notes and treatment details in your Patient Portal may be visible to individuals who have been granted access, such as parents, guardians, or other authorized parties.

If it becomes necessary to release information, it will be done in such a way as to protect the confidentiality of clinical information, as much as possible. We want to assure all clients of our commitment to maintain confidentiality and that their case will be handled professionally and with the highest degree of confidentiality possible.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Client Fee Information

1. Each appointment we have available is an opportunity for our team to help a person or family in need. Appointments missed or cancelled less than 24 hours in advance will result in a fee (**$20 for Counseling & $50 for Psychiatry**). Please notify us well in advance if you cannot attend an appointment so that someone else can be seen during that time.
2. Payment is expected at the time services are provided. If you are unable to pay your sessions fees or copayments at the time of service, your appointment may be rescheduled.
3. A valid credit card is required to be kept on file and will be charged at the time of service for all services rendered. Charges for no-shows and late cancellations (less than 24 hours' notice) will be processed within two weeks, allowing time for clinician review. For insurance claims, deductible and coinsurance amounts under $150 will be charged automatically. If the balance exceeds $150, 20% will be charged upfront, and the remaining amount will be arranged directly with the client. A payment plan may be available if unable to pay the whole balance.
4. All prepaid assessment fees are non-refundable.
5. Insurance and income verification must be submitted prior to or at the first appointment.
6. The client seeking services or parent/guardian seeking services for minor children is responsible for all fees not paid by insurance.
7. By providing Provident with your insurance information, you are consenting to allow information regarding diagnosis, treatment plan, and clinical information to be disclosed to your insurance company for the purposes of claim filing and insurance reimbursement.
8. Insurance deductibles must be met in order for insurance to fund services at Provident. Fees charged to you will equal the standard rate required for all services provided until the deductible is met.
9. The fee for service without insurance will be based on our self-pay scale. The fee for service will be determined by the total household income and household size. Proof of income must be provided in order to be assigned a reduced fee for self-pay services.
10. If a client chooses not to use insurance, the standard out-of-pocket rate is required for all services.
11. Past due balances may interfere with the ability to schedule future appointments.
12. Cash, checks, money orders, and credit cards are acceptable forms of payment.
13. If you have any questions concerning your fees, charges, or payments that cannot be answered at the location where your services are provided, please call our **Relations Coordinator at 314-802-2647**.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Consent to Telehealth Services

Provident offers telehealth appointments, which use video conferencing to meet with your provider without being in the office. Telehealth is available to clients with video conferencing capabilities on their smart phone, computer, or tablet with webcam and microphone, as well as strong internet connectivity that supports participating in a video conference with good audio and video quality.

By participating in telehealth services with Provident, you are indicating consent to receive services delivered via video conference. Provident uses a HIPAA compliant account and has a Business Associate Agreement with Zoom, the video conferencing software company. There are advantages, disadvantages, and limitations regarding the security of confidential information when utilizing telehealth, which will be discussed with your provider. Provident's providers work to maintain the same level of care and professionalism that you would receive during an office-based visit. Your consent also indicates that you will, to the best of your ability, participate in your telehealth service in a confidential space in your own home to provide yourself the best atmosphere for your appointments.

After reading pages 1-5, sign the corresponding sections of the Signature Page (pg. 6) or electronic consent.

Telehealth Appointment Instructions

To prepare for your telehealth appointment:

1. Download the Zoom app to your device (smart phone, tablet, computer)
2. Allow the Zoom app to access to your camera and microphone to enable audio and video for telehealth.
3. **New Clients:** Complete your Consent Forms, Intake Survey, and any other forms assigned to you in your ClinicTracker Patient Portal. A link to verify your Patient Portal account will be sent from ClinicTracker, our electronic health record software company. Please check your junk mail if you do not see the verification email in your inbox.
4. Locate a quiet, confidential space in your home to participate in your telehealth session. Minimize distractions as much as possible. This time is for you!
5. **To join your appointment:** Access the Zoom meeting link in your Patient Portal Message or email. ***Copy and paste the link in your web browser.***
6. If you have not received your Zoom meeting link for your appointment, please contact the front desk at the site where your provider works:

Counseling:	**St. Louis City (Olive Street):** 314-371-6500	**Creve Coeur (Ladue Road):** 314-898-0100
	South (Tesson Ferry Road): 314-898-0102	
Psychiatric Services:	314-802-2670	

Your Patient Portal

Access your ClinicTracker patient portal to complete forms, see upcoming appointments, pay your copay or balance, access your telehealth link, or message our support team.

Please list any additional individuals you would like to grant access to your Patient Portal and specify what information they may view.

Grant Patient Portal Access to:

☐ Myself/Client: Name *(first & last)*: _____ Email: _____

☐ Parent/Guardian 1: Name *(first & last)*: _____ Email: _____

Select Patient Portal access you are granting to this user:

☐ Demographics ☐ Form Requests ☐Clinical Info ☐ Schedule ☐ Financial Account ☐Education Resources ☐ Messages

☐ Parent/Guardian 2: Name *(first & last)*: _____ Email: _____

Select Patient Portal access you are granting to this user:

☐ Demographics ☐ Form Requests ☐Clinical Info ☐ Schedule ☐ Financial Account ☐Education Resources ☐ Messages

☐ Other: _____ Name *(first & last)*: _____ Email: _____

(Specify Relationship)

Select Patient Portal access you are granting to this user:

☐ Demographics ☐ Form Requests ☐Clinical Info ☐ Schedule ☐ Financial Account ☐Education Resources ☐ Messages

Website: https://portal.clinictracker.com
Clinic ID: PRO

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Signature Page

Child's Name: _____ Birth Date: __/__/_____ Parent's Name(s): _____
First, Middle, & Last

Contact Information:

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Provident may contact me and leave a message by (check all that apply): ☐ Voicemail ☐ US Mail ☐ Text Message
☐ **Please do not** contact me in the following ways: _____

In the case of any emergency, please notify:

Name: _____ Relationship: _____ Phone: _____

☐ Address same as client Address: _____ City: _____ State: _____ Zip: _____

Consent to Treatment

I have reviewed the Consent to Treatment policies, they have been explained to me, and I understand them. I request services from Provident.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Client Rights and Responsibilities

I have reviewed the Client Rights and Responsibilities policies, they has been explained to me, and I understand them.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy Practice

I have reviewed the Notice of Privacy Practice policies, they have been explained to me, and I understand that Provident follows HIPAA privacy laws and will protect the confidentiality of my protected health information.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Statement of Confidentiality

I have reviewed and understand the Statement of Confidentiality policy and understand the extent to which Provident is permitted to disclose information about me.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Client Fee Information

I have reviewed the Client Fee Information policy, it has been explained to me, and I understand the fees associated with services and missed appointments.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Consent to Telehealth Services

I have reviewed and understand the Consent to Telehealth Services and consent to participate in telehealth services, when appropriate and available.

Client/Guardian Signature: _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Fee Determination Form

Client Name: _____ **Client DOB:** _____

Parent Name/Name of Insured: _____ **Insured DOB:** _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell/Other Phone #:** _____

Billing Address (if different than Home): _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Insurance Information: ☐ I have insurance ☐ I do not have insurance

Name of Primary Insurance Company: _____ ID#: _____ Group ID: _____

Insurance Card Holder Name: _____ Copay: $_____ Deductible: $_____

Name of Secondary Insurance Company: _____ ID#: _____ Group ID: _____

Insurance Card Holder Name: _____ Copay: $_____ Deductible: $_____

Employment Information: ☐ I am employed ☐ I am not employed

Household Income Information: Please provide income information for all members in your household

Gross Household Income		
Family Member	**Employer Name**	**Annual Income**
Self:		$
Significant Other (if living together)**:**		$
Other Family Members in Household:		$
Child Support/Alimony Received (annual amount):		$
If you did not file a Tax Return, please note Annual Gross Income (before taxes):		$
Total Annual Gross Household Income:		$
Total # of people living in household (including yourself):		
Fee amount for Self-Pay Services is based on Total Gross Household Income and household size. Household income information is gathered on all clients to better understand the demographic background on all of our clients. Your income will not negatively impact your ability to receive services.	**Counseling** Mental Health Assessment Individual & Family Therapy **Psychiatric Services** Psychiatric Evaluation: Follow Up/Medication Management:	**Max out of pocket fees** $140 $140 $240 $150

I understand that all payments and co-payments are due at time of service. An appointment cancellation notice is required 24 hours in advance to avoid a charge being made to me. I authorize release of any medical or other information necessary for my insurance company/funding source to process claims for services received. I authorize that payment from my insurance company, Medicare, or Medicaid be made on my behalf to Provident for any services provided to me by the agency. I also request payment of government benefits to the party who accepts assignment. This consent remains in my file and can be revoked by me at any time upon written request by me to Provident. If my particular insurance carrier or funding source does random site reviews or audits, I understand that representatives review the contents of my file.

My signature indicates I have read and understand all of the above.

Client/Guardian Signature(s): _____ Date: _____

_____ Date: _____

Witness Signature: _____ Date: _____

Please attach copies of:

1. **If insured: Insurance, Medicare, and Medicaid Cards** (front & back)
2. **If self-pay: IRS 1040 Tax Return Form or 2 most recent Paycheck Stubs, Benefit Statement** (for Unemployment or Social Security Disability), or other proof of income.

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Client Name: _____ **Date Completed:** _____

Purpose: Effective December 15th, 2025, Provident Behavioral Health requires a valid credit or debit card to be kept on file to cover patient financial responsibility, including copayments, deductibles, coinsurance, self-pay balances, and late cancellation/no show fees. This ensures timely payment and reduces billing delays.

Authorization

I, the undersigned, authorize **Provident Behavioral Health** to securely store my credit card information within its PCI DSS–compliant payment system and to charge my card as described below:

1. **Time of Service Charges**
   - My card will be charged for copayments and self-pay balances on the date of service.
2. **Late Cancellation / No Show Fees**
   - If applicable, fees will be charged within **two (2) weeks** of the original appointment date, allowing clinicians time to determine whether the fee applies.
3. **Insurance Balances**
   - Deductibles and coinsurance amounts under $150 will be charged to my card when the Explanation of Benefits (EOB) is received from my insurance company.
   - Deductibles and coinsurance amounts over $150 will be charged as follows:
     - 20% of the balance charged when the EOB is received, and
     - The remainder charged only after I am notified. I may request a payment plan for the remaining balance.
4. **Notifications**
   - I will be notified prior to any charge exceeding $150.

To maintain privacy of credit card information, I will be required to verbally share credit card information in-person or over the phone with Provident staff to have a credit card saved in my file.

If you have concerns about this policy, please contact your office to discuss your situation to explore what other options may be available.

Revocation of Authorization

I understand that I may revoke this authorization at any time by submitting a written request. If I revoke authorization, I must make alternative payment arrangements (such as paying in full at the time of service).

Acknowledgment

- I understand that my card information will be stored securely and that Provident Behavioral Health staff will not have access to the full card number after entry.
- I understand that it is my responsibility to contact my clinician's office via phone or in-person to provide credit card details verbally.
- I understand that the authorization form for this card will remain in effect until the card expires or a written revocation is received. If the card expires or becomes inactive, I acknowledge that it is my responsibility to inform my office of the change and provide updated credit card information.
- I authorize Provident Behavioral Health to charge my card in accordance with this policy.
- I understand that failure to maintain a valid card on file or alternative payment arrangement may affect my ability to continue receiving services.

BILLING INFORMATION

Cardholder Name: _____ Card Type: _____ last 4 digits on card #: _____
Ex. Visa, Discover, Mastercard, etc.

Billing Address: _____

Phone #:_____ Email: _____

By signing below, I authorize Provident Behavioral Health to charge the credit card indicated in this authorization form according to the abovementioned terms. This payment authorization is for the services described above. I certify that I am an authorized user of this credit card and will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Cardholder Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Revocation of Authorization

Client Name: _____ Do not charge this card as of this date: _____

Cardholder Name: _____ Card Type: _____ last 4 digits of card #: _____

Ex. Visa, Discover, Mastercard, etc.

Revocation of Authorization

I revoke my authorization to use the credit/debit card on file that was previously authorized by this form. I understand that I am required to provide alternative payment arrangements, including but not limited to authorizing use of a different credit/debit card.

Revocation Signature: _____ Date: _____

To be signed by client/guardian/cardholder

Staff Signature: _____ Date: _____

Staff signature verifies that the revocation has been processed and the card on file will not be charged for future fees following the revocation date listed above.

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Guardianship Information Form

Please provide information regarding who is allowed to make medical decisions on behalf of your child.

Child Name: _____ **Birth Date:** _____

Name(s) of Parent(s) Accompanying Child to Treatment: _____

Guardian Participation in Appointments

To ensure the best care for your child, we strongly encourage all legal guardians to attend clinical appointments. These visits may involve important decisions about your child's treatment, including medication changes or adjustments to therapy. If only one guardian is present during an appointment, it will be assumed that the absent guardian is informed of and agrees with any treatment decisions made, including changes to prescribed medications. If this is not the case, please notify our staff in advance so we can make appropriate arrangements.

1. **Are you the child's sole legal guardian(s)?** ☐ Yes ☐ No

   If **Yes**, skip questions 2-6

   If **No**, please provide contact information for child's other legal guardian and respond to items 2-6.

2. **Contact Information for other parent not accompanying child to treatment:**

   Parent Name: _____ Phone: _____

   Address: _____ ☐ Same as Child's Address

   _____

3. **What is your current relationship status with your child's other parent or legal guardian?**

   ☐ Together ☐ Separated ☐ Divorced

   ☐ N/A – I am the child's only parent (other parent is deceased or has never been involved)

   *If **parents are married or you are your child's only legal guardian**, skip questions 4-6. No additional information.*

   *If **otherwise, if parents are separated, divorced, have custody arrangement, or other situation**,, please answer questions 4-6.*

4. **If not together, what type of custodial agreement do you have?** _____

5. **Does the other parent/guardian consent that your child can participate in services?** ☐ Yes ☐ No

6. **Do you have the ability to make medical decisions without the other parent's consent?** ☐ Yes ☐ No

   *If **Yes**, please provide a copy of the **court paperwork** that gives you this right.*

   *If **No**, please provide the **contact information** (phone and address) for the other parent.*

***Please note:** It is in the best interest of the child that both parents support their involvement in treatment. If you and your child's other parent are no longer together and you do not have sole guardianship of your child, your child may not be able to be seen for any future appointments until their other parent or guardian has provided written or verbal consent allowing him or her to engage in treatment at Provident. For separated or divorced parents who have shared custody and shared ability to make medical decisions regarding a child's medical treatment, both parents' consents are required for the child to engage in services at Provident.*

For Provident Staff only:

Parent not accompanying child to session has provided **consent**? ☐ Yes ☐ No ☐ N/A

Type of Consent Obtained: ☐ Verbal ☐ Written Date Consent Obtained: ____/_____/_____

Consent Obtained via: ☐ Phone/verbally ☐ Signed Consent Forms ☐ Other: _____

Guardianship Notes: _____

Signature of Staff Verifying Consent Provided: _____

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

Parent Questionnaire

Child's Legal Name: _____ Birth Date: ___/___/_____ Age: ____ Sex at Birth: ☐ Male ☐ Female

Preferred/Chosen Name: _____ Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Race/Ethnicity: ☐ Black or African American ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ Biracial/Multiracial
☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Other/Describe: _____

Child's Sexual Orientation: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Questioning ☐ Other: _____

Who referred you to Provident? _____

PRESENTING CONCERNS

What problems or concerns bring you and your child to Provident today? (Include when problem began, how often, triggers, etc.)

_____

_____

What do you hope to accomplish through treatment? _____

_____

FAMILY INFORMATION

Primary Parent/Guardian 1: _____ *Full name*
Relationship with child: ☐ Mother ☐ Father ☐ Grandparent ☐ Other:_____
Date of Birth: ____/____/_____
Education: _____
Occupation: _____

Primary Parent/Guardian 2: _____ *Full Name*
Relationship with child: ☐ Mother ☐ Father ☐ Grandparent ☐ Other:_____
Date of Birth: ____/____/_____
Education: _____
Occupation: _____

Marital Status of Child's Parents (select all that apply): ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Living Together
☐ Mother Remarried ☐ Father Remarried ☐ Parent Deceased ☐ Other: _____

Child Age at time of Separation/Divorce: _____
If parents are divorced or separated: Who has legal custody? _____ Who has financial responsibility? _____

Is there court mandated child support? ☐ Yes ☐ No If yes, is it paid regularly? ☐ Yes ☐ No

List any additional parental figures and their relationship to the child: _____

Do You Live In an: ☐ Apartment ☐ House ☐ Other: _____ Do you: ☐ Rent ☐ Own

Annual Family/Household Income: $_____ **Total # of people living in the household: _____**

Do you use assistance to pay utility bills or other expenses? ☐ Yes ☐ No If yes, explain: _____

Is there enough food and clothing in the household? ☐ Yes ☐ No

What is your living situation? ☐ Stable ☐ Unstable ☐ Homeless ☐ Dangerous or Hazardous

With whom does your child live?

Name of Household Member	Age	Relationship to Child

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

SCHOOL HISTORY

Child's School: _____ Grade: _____ Teacher: _____

Is your child attending: ☐ Regular Classroom ☐ Regular Class & Resource Room ☐ Learning Disabilities Classroom ☐ Special Class ☐ Behavior Classroom ☐ Other: _____

Has your child ever been suspended from school? ☐ Yes ☐ No ☐ Once ☐ Infrequently ☐ Frequently

Has the child ever changed schools or school districts? ☐ Yes ☐ No If Yes, why? _____

Has your child had an Individualized Education Program (IEP)? ☐ Yes ☐ No If Yes, when? _____

Has your child ever repeated a grade? ☐ Yes ☐ No If Yes, what grade(s)? _____

Has your child been attending school regularly? ☐ Yes ☐ No If No, why? _____

Has your child ever been fearful or reluctant to attend school? ☐ Yes ☐ No If Yes, when? _____

Does your child complete his or her homework regularly? ☐ Yes ☐ No

Does your child require help completing homework? ☐ Yes ☐ No

Does your child have behavior or academic problems at school? ☐ Yes ☐ No

If Yes, explain: _____

_____

WORK HISTORY

Does your child have a job? ☐ Yes ☐ No

If Yes: Job Title: _____ Employer: _____ Hours Worked Weekly: ____

PEER RELATIONSHIPS

Does your child seek friendships? ☐ Yes ☐ No

Is your child sought by peers for friendships? ☐ Yes ☐ No

Does your child play with children his or her own age? ☐ Yes ☐ No ☐ Younger ☐ Older

Is your child having problems with friends or in social situations? ☐ Yes ☐ No

If Yes, explain: _____

My child's support system includes: ☐ Many friends and family ☐ few friends or family ☐ no support system

HOME BEHAVIOR

Who typically disciplines your child? ☐ Mother ☐ Father ☐ Both Parents ☐ Other: _____

What techniques do you use to discipline your child? _____

Have these methods been effective? ☐ Yes ☐ No

How well does your child get along with his or her brothers and sisters?
☐ Very Well ☐ Average ☐ Arguments ☐ Avoids ☐ Frequent Fights ☐ Jealousy ☐ Is Teased ☐ Teases

Does your child share a bedroom? ☐ Yes ☐ No If yes, with whom? _____

Does your child experience any sleep problems (ex. difficulty falling or staying asleep, problematic dreams)? ☐ Yes ☐ No

If Yes, explain: _____

Has your child had any changes in appetite? ☐ Yes ☐ No

If Yes, explain: _____

Has your child had any frightening or traumatic experiences *(including accidents, losses, abuse, neglect, or exploitation)*? ☐ Yes ☐ No

If Yes, explain: _____

Have you ever been involved with Children's Services (DFS, DCFS, Children's Division)? ☐ Yes ☐ No

If Yes, explain: _____ ☐ Currently Involved

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

Has anyone been physically or sexually abusive to your child? ☐ Yes ☐ No

If Yes, please describe _____

Has your child witnessed physical or sexual violence? ☐ Yes ☐ No

If Yes, please describe: _____

LEGAL HISTORY

Has your child ever been arrested? ☐ Yes ☐ No If Yes, why? _____
Has your child ever been convicted of a crime? ☐ Yes ☐ No If Yes, what was the charge(s)? _____
Is your child under court supervision or required to meet with a Juvenile Officer (DJO)? ☐ Yes ☐ No

SUBSTANCE USE HISTORY

Does your child smoke cigarettes or use nicotine products? ☐ Yes ☐ No If Yes, how much/how often? _____
Does anyone in the home smoke/use nicotine products? ☐ Yes ☐ No If Yes, who? _____
Would you like information about smoking cessation? ☐ Yes ☐ No
To your knowledge, has your child ever used alcohol or drugs? ☐ Yes ☐ No
If Yes, please describe (include substances used & how often): _____

Is there any family history of drug or alcohol abuse? Please explain: _____

MENTAL HEALTH HISTORY

Has your child had previous counseling, psychotherapy, or psychiatric care? ☐ Yes ☐ No
If Yes, describe past treatment dates, services received, medications prescribed, & previous diagnoses.

_____

_____

What traumatic or difficult events has your child experienced? _____

_____

Have any immediate family members experienced mental health issues or participated in treatment? ☐ Yes ☐ No
If Yes, please describe relation to child, diagnosis/problem, and any treatment received.

_____

_____

ADDITIONAL HISTORY

What activities/hobbies/interests does your child enjoy? _____
Who does your child depend upon for emotional support? _____
Does your child use community resources or self-help groups? _____
What is your child's religious background? _____
Is your child active in any religious or spiritual practices? ☐ Yes ☐ No Describe: _____

MEDICAL HISTORY

Child's Current Height: _____ Current Weight: _____ Date of Last Exam: ____/____/_____
Primary Care Provider: _____ Practice Name/Location: _____
Phone Number: _____ ☐ Provident can coordinate care with my primary care provider
Please list any other doctors or specialist you work with and what issues they are treating you for: _____

Provident Behavioral Health

Client Name: _____
DOB: ___/___/____
Date Completed: ___/___/____

MEDICAL HISTORY (continued)

Length of Pregnancy: ☐ Full Term ☐ Premature (____ weeks) Alcohol/drug use during pregnancy? ☐ Yes ☐ No

Complications, illness or accidents during pregnancy, birth, or infancy? ☐ Yes ☐ No

If Yes, explain: _____

Were developmental milestones (sitting, walking, talking, potty training): ☐ Early ☐ Normal ☐ Late

Describe skills developed late or early: _____

Indicate which of the following medical conditions ***currently*** affect your child:

☐ Acid Reflux	☐ Allergies	☐ Asthma	☐ Autoimmune Disorder	☐ Birth Defects
☐ Cancer	☐ Chest Pain/Pressure	☐ Chronic Pain	☐ Constipation	☐ Cough
☐ Diabetes	☐ Diarrhea	☐ Difficulty Breathing	☐ Difficulty Speaking	☐ Difficulty Swallowing
☐ Dizziness/Vertigo	☐ Ear Pain	☐ Eating Disorder	☐ Epilepsy/Seizures	☐ Fatigue
☐ Fever/Chills/Sweats	☐ Eye Pain	☐ Glaucoma	☐ Headaches/Migraines	☐ Hearing Loss
☐ Heart Disease	☐ Heart Attack	☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ Kidney Problems	☐ Kidney Disease/Dialysis	☐ Liver Problems	☐ Loss of Appetite	☐ Menstrual Problems
☐ Nasal Congestion	☐ Pregnancy	☐ Shortness of Breath	☐ Sickle Cell	☐ Sleeping Problems
☐ Stomach Pain/Problems	☐ Stroke	☐ Thyroid Disorder	☐ Traumatic Brain Injury	☐ Urinary Problems
☐ Vision Problems	☐ Vomiting	☐ Weight Change (loss/gain)	☐ Difficulty Walking/Coordinating Movements	

☐ Other: _____

Is your child currently being treated for the medical conditions listed above? ☐ Yes ☐ No

Describe any history of serious medical conditions, illnesses, or surgeries: _____

Please list any allergies your child has (food, medication, seasonal, etc.): _____

Is your child current with immunizations? ☐ Yes ☐ No If No, explain: _____

Family history of medical issues *(include medical issue and family member relationship):* _____

Current Medications: Please list all prescriptions, over the counter medications, and supplements your child is currently taking.*

Medication Name	Dosage/Frequency	Start Date	Prescribing Physician	Side Effects

Does your child take the medicine as prescribed? ☐ Yes ☐ No

*attach medication list, if needed

Pain Screen: On a scale of 1 to 10, what is the present level of **physical** pain your child is experiencing? *(circle one)*

0 1 2 3 4 5 6 7 8 9 10
No Pain **Extreme Pain**

Location of Pain: ☐ Muscular ☐ Joint ☐ Neck ☐ Back ☐ Other: _____
Does your child's pain affect his/her daily activities? ☐ Yes ☐ No

Nutrition Screen: *Please answer the following about your child's nutritional habits. Please explain any items marked "yes".*

Yes	No	My child…	Explanation:
1	0	1. Has had a decreased appetite/has been eating less than normal.	Decreased appetite has lasted for: ____ **(#) days/weeks/months**
1	0	2. Has lost or gained at least 10 pounds in the last **3** months.	_____ pounds ☐ gained ☐ lost
1	0	3. Has an allergy, illness, or condition impacts how they eat.	Explain:
1	0	4. Requires a special diet.	Explain why special diet is needed and if child adheres to diet:
1	0	5. Has dental problems that make it hard to eat.*	Describe tooth or mouth pain/problems:
1	0	6. Eats fewer than 2 meals per day.	
1	0	7. Eats too few fruits or vegetables or milk products.	
1	0	8. Our family does not always have enough money to buy the food our child needs.**	
1	0	9. Has been binge eating (eating large quantities of food at once).	
1	0	10. Has been forcing himself/herself to vomit after eating.	
1	0	11. Has been excessively active to burn off calories consumed.	
1	0	12. Has been concerned with weight and/or restricting calories.	
Total Score:		**Score Interpretation:** Scores of 4-7 = use clinical judgement to determine referral needs. Scores of 8+ = refer to doctor, nutritionist, or other appropriate resource(s). *Refer to dental care if dental problems are noted. **Refer to resources for food if family needs assistance.	

Provident Behavioral Health

Administrative Office
2650 Olive Street
St. Louis, Missouri 63103
314-371-6500

Ohio Youth Problem, Functioning, & Satisfaction Scale

Client Name: _____ DOB: ___/___/_____ Date Completed: ___/___/_____

Completed by: ☐ Client/Self ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Guardian ☐ Other: _____

Problem Severity Scale

Instructions: Please rate the degree to which you/your child have experienced the following problems in the ***past 30 days.***	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

Total Problem Severity Score _____

Functioning Scale

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your/your child's ***current*** situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

Total Functioning Score _____

Provident Behavioral Health

Client Name: _____
DOB: ___/___/_____
Date Completed: ___/___/_____

Hope & Satisfaction Scales

Youth Version: If you are the *child/client*, please complete these questions:

Hopefulness Scale	Satisfaction Scale
Instructions: please circle your response to each question.	**Instructions:** please circle your response to each question.
1. Overall, how satisfied are you with your life right now? 1. Extremely satisfied 2. Moderately satisfied 3. Somewhat satisfied 4. Somewhat dissatisfied 5. Moderately dissatisfied 6. Extremely dissatisfied	1. How satisfied are you with the mental health services you have received so far? 1. Extremely satisfied 2. Moderately satisfied 3. Somewhat satisfied 4. Somewhat dissatisfied 5. Moderately dissatisfied 6. Extremely dissatisfied
2. How energetic and healthy do you feel right now? 1. Extremely healthy 2. Moderately healthy 3. Somewhat healthy 4. Somewhat unhealthy 5. Moderately unhealthy 6. Extremely unhealthy	2. How much are you included in deciding your treatment? 1. A great deal 2. Moderately 3. Quite a bit 4. Somewhat 5. A little 6. Not at all
3. How much stress or pressure is in your life right now? 1. Very little stress 2. Some stress 3. Quite a bit of stress 4. A moderate amount of stress 5. A great deal of stress 6. Unbearable amounts of stress	3. Mental health workers involved in my case listen to me and know what I want. 1. A great deal 2. Moderately 3. Quite a bit 4. Somewhat 5. A little 6. Not at all
4. How optimistic are you about the future? 1. The future looks very bright 2. The future looks somewhat bright 3. The future looks OK 4. The future looks both good and bad 5. The future looks bad 6. The future looks very bad. **Total:** _____	4. I have a lot to say about what happens in my treatment. 1. A great deal 2. Moderately 3. Quite a bit 4. Somewhat 5. A little 6. Not at all **Total:** _____

Parent Version: If you are the *parent/guardian*, please complete these questions:

Hopefulness Scale	Satisfaction Scale
Instructions: please circle your response to each question.	**Instructions:** please circle your response to each question.
1. Overall, how satisfied are you with your relationship with your child right now? 1. Extremely satisfied 2. Moderately satisfied 3. Somewhat satisfied 4. Somewhat dissatisfied 5. Moderately dissatisfied 6. Extremely dissatisfied	1. How satisfied are you with the mental health services your child has received so far? 1. Extremely satisfied 2. Moderately satisfied 3. Somewhat satisfied 4. Somewhat dissatisfied 5. Moderately dissatisfied 6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now? 1. Extremely capable 2. Moderately capable 3. Somewhat capable 4. Somewhat incapable 5. Moderately incapable 6. Extremely incapable	2. To what degree have you been included in the treatment planning process for your child? 1. A great deal 2. Moderately 3. Quite a bit 4. Somewhat 5. A little 6. Not at all
3. How much stress or pressure is in your life right now? 1. Very little 2. Some 3. Quite a bit 4. A moderate amount 5. A great deal 6. Unbearable amounts	3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child. 1. A great deal 2. Moderately 3. Quite a bit 4. Somewhat 5. A little 6. Not at all
4. How optimistic are you about your child's future? 1. The future looks very bright 2. The future looks somewhat bright 3. The future looks OK 4. The future looks both good and bad 5. The future looks bad 6. The future looks very bad. **Total:** _____	4. To what extend does your child's treatment plan include your ideas about your child's treatment needs? 1. A great deal 2. Moderately 3. Quite a bit 4. Somewhat 5. A little 6. Not at all **Total:** _____