Client Name:_____

Male or Female (circle one) Are you pregnant? Yes____ No ____

What is your Gender Identity?

Male ____ Female ____ Gender Variant/Non-Conforming ____ Transgender Female ____
Transgender Male ____ Prefer Not to Answer ____ Not Listed ____

Do you consider yourself to be in mental health crisis today? Yes or No
In the past two weeks, have you felt that you or others would be better off without you? Yes or No
In the past two weeks, have you had any thoughts of harming yourself or others? Yes or No
Is this child in foster care? Yes or No

Description of Concern (Why you are coming in today):

_____

_____

Guardian Name (if under 18): _____

Client DOB: _____

Client SS#: _____

Client Address: _____

Client Phone #: _____

Insurance Company and Policy #: _____

Are you a Veteran? Yes ___ No ___
If you are under the age of 18, is the parent(s) a Veteran? Yes ___ No ___

Appointment Reminders: Phone Call ____ Text Message ____ Email ____ All ____
Join the Patient Portal: Yes ____ No ____

Email Address: _____

Race: _____ Hispanic or Latino ____ Not Hispanic or Latino ____

Emergency Contact Name/Number/Relationship:

_____

_____

Elizabeth Layton Center, Inc.
Child Registration Form

Please Answer ALL Questions

Child's Name: _____ ***DOB:*** _____ ***SS#*** _____

Guardian Information:

___Mother ___Step Mother ___Foster ___Grandmother ___Lives with ___Has Legal Custody

Name: _____ **DOB:** _____ **SS#:** _____

Phone: _____ **Address:** _____

___Father ___Step Father ___Foster ___Grandfather ___ Lives with ___ Has Legal Custody

Name: _____ **DOB:** _____ **SS#:** _____

Phone: _____ **Address:** _____

Legal Custody (If not listed above)

Name: _____ **Address:** _____

Relationship: _____ **Phone #:** _____

SSI/SSDI Eligibility:

- ☐ Not Applicable
- ☐ Eligible and Receiving Payments
- ☐ Eligible, but NOT Receiving Payments
- ☐ Potentially Eligible (Case Not Yet Submitted)
- ☐ Determined to be ineligible by Review & Decision
- ☐ Determination decision on Appeal

Most Recent Psychiatric Hospitalization:

- ☐ None/Never
- ☐ State Mental Health Hospital
- ☐ Private Psychiatric Hospital
- ☐ General Hospital Psychiatric Ward
- ☐ Inpatient Substance Abuse (Excluding Detox)
- ☐ Residential Mental Health Treatment

Current Custody:

- ☐ Child in JJA Custody or Supervision
- ☐ Child in DCF Custody & Out of Home Placement
- ☐ Child in DCF Custody & Lives at Home
- ☐ Child under DCF supervision, not DCF custody
- ☐ NO JJA or DCF Involvement

Current Residential Setting:

- ☐ Crisis Resolution/Stabilization Unit
- ☐ Emergency Shelter
- ☐ Foster Home
- ☐ Group Home (Levels III/IV/V)
- ☐ Homeless
- ☐ Independent Living
- ☐ Inpatient Psychiatric Hospital
- ☐ Jail/Detention Center
- ☐ Temporarily Living w/Relative/Family/Friend
- ☐ Permanent (Biological/Adoptive/other)
- ☐ Residential Treatment Level VI
- ☐ Other _____

Gross Household Income: $_____

- ☐ Monthly
- ☐ Yearly

# of Members in Household: _____

Current Grade Level: _____

Name of School Attending: _____

Current Education:

- ☐ Not applicable/Not Listed Below
- ☐ Preschool
- ☐ K- 11 (Last year completed) _____
- ☐ Enrolled in Post-Secondary Education
- ☐ Other: _____

Special Education:

- ☐ Not Applicable
- ☐ Regular Classroom with Special Education
- ☐ Special Education (Type)
- ☐ Alternative Education Placement
- ☐ Home-Based School
- ☐ Other _____

Tobacco/Smoker Status (Age 10 and Older):

Tobacco User: Yes ____ NO ___
Tobacco User Current: Yes___ NO___
Smokeless Tobacco Yes ____ NO
Smoker: Yes___ NO___
Use a Vape Device: Yes___ NO___
Smoking Status:
____Never a Smoker ____Current Every Day
____Former Smoker _____Current Some Days
____Light Smoker _____Heavy Smoker
____Smoker Status Unknown
Information not obtained Reason_____

Court/Legal Information:

Attorney: _____
PO: _____
Court: _____
Court Date: _____
Other Info: _____

Family Physician: _____

Referred to ELC by: _____

Religious Preference: _____

Clinical Intake Questionnaire

Client Name: _____

Please state in your own words the nature of your main concern(s) (i.e., what you are now coming to this center: _____

_____

How long have these concerns existed? _____

On the scale below, please estimate the severity of your concern(s) Circle one:

Not very upsetting ***Mildly upsetting*** ***Upsetting*** ***Severe*** ***Very Severe***

Please explain benefits you hope to derive from coming to this center: _____

_____

Circle any of the following that apply to client:

Health Problems	Take Drugs	Unable to Relax	Secure
Need to Change	Considerate	Overeating	Friendly
Exhausted	No Appetite	Shakiness	Nervous
Feel Panicky	Fearful	Can't Keep a Job	Happy
Work Problems	Running Away	Spouse Difficulties	Attractive
Inferiority	Evil	Shy with People	Suicidal
Bad Home Life	Morally Wrong	Independent	Worthwhile
Hearing Voices	School Problems	Guilty	Depressed
Lonely	Can't Make Friends	Life is Empty	Content
Angry	Aggressive	Poor Concentration	Fatigue
Nightmares	Emotional Problems	Tell Lies	Feel Tense
Immature	Misunderstood	Confident	Suspicious
Drinks too much	Easily Excited	Religious Concerns	Confused
Unattractive	Sleeping Problems	Failure	Unassertive
Money Problems	Dizziness	Parental Problems	Intelligent
Sexual Problems	Headaches	School Problems	
In Conflict	Can't Do Anything Right	Other: _____	

Please check the services that could help you with your present concern(s):

Individual Counseling ___	Marital Counseling ___
Group Therapy ___	Relaxation Training ___
Family Counseling ___	Child Play Therapy ___
Social Skills and Communication ___	Understanding Personality Makeup ___
Substance Abuse Treatment ___	Assertiveness Training ___
Rape Victim Counseling ___	Parent Effectiveness Training ___
Medication Management ___	Other: _____

Please list client's hobbies and recreational interests: _____

_____

ELIZABETH LAYTON CENTER
For Hope and Guidance

MISSION OF THE ELIZABETH LAYTON CENTER

Elizabeth Layton Center provides comprehensive and integrated behavioral health services for our community.

Availability of Services: Services of our Center are available to all residents of Franklin County and Miami County regardless of race, color, sex, creed, handicap, religion or ability to pay.

STATEMENT OF CLIENT RIGHTS

To always be treated with dignity and respect, and not to be subjected to any verbal or physical abuse or exploitation;

To not be subjected to the use of any type of treatment, technique, intervention, or practice, including the use of any type of restraint or seclusion, performed solely as a means of coercion, discipline, or retaliation, or for the convenience of staff or any volunteer or contractor;

To receive treatment in the least restrictive, most appropriate manner;

To an explanation of the potential benefits and any known side effects or other risks associated with all medications that are prescribed for the client;

To an explanation of the potential benefits and any known adverse consequences or risks associated with any type of treatment that is not included in the aforementioned paragraph and that is included in the client's treatment plan;

To be provided with information about other clinically appropriate medications and alternative treatments, even if these medications or treatments are not the recommended choice of that client's treating professional;

The right of a client voluntarily receiving treatment to refuse any treatments or medications to which that client has not consented, in compliance with the client's rights;

The right of a client involuntarily receiving treatment pursuant to any court order to be informed that there may be consequences to the client if the client fails or refuses to comply with the provisions of the treatment plan or to take any prescribed medication;

To refuse to take any experimental medication or to participate in any experimental treatment or research project, and the right not to be forced or subjected to this medication or treatment without the client's knowledge and express consent, given in compliance with the client's rights, or as consented to by the client's guardian when the guardian has the proper authority to consent to this medication or treatment on the client's behalf;

To actively participate in the development of an individualized treatment plan, including the right to request changes in the treatment services being provided to the client, or to request that other staff members be assigned to provide these services to the client;

To receive treatment or other services from ELC in conjunction with treatment or other services obtained from other licensed mental health professionals or providers who are not affiliated with or employed by ELC, subject only to any written conditions that ELC may establish only to ensure coordination of treatment or any services;

To be accompanied or represented by an individual of client's own choice during all contacts with ELC. This right shall be subject to denial only upon determination by professional staff that the accompaniment or representation would compromise either that client's rights of confidentiality or the rights of other individuals, would significantly interfere with that client's treatment or that of other individuals, or would be unduly disruptive to ELC's operations;

To see and review the clinical record maintained on that client, unless the Executive Director of ELC has determined that specific portions of the record should not be disclosed. This determination shall be accompanied by a written statement placed within the clinical record required by K.A.R. 30-60-46, explaining why disclosure of that portion of the record at this time would be injurious to the welfare of that client or to others closely associated with that client;

To have staff refrain from disclosing to anyone the fact that the client has previously received or is currently receiving any type of mental health treatment or services, or from disclosing or delivering to anyone any information or material that the client has disclosed or provided to any staff member of ELC during any process of diagnosis or treatment. This right shall automatically be claimed on behalf of the client by ELC's staff unless that client expressly waives the privilege, in writing, or unless staff are required to do so by law or a proper court order;

To exercise the client's rights by substitute means, including the use of advance directives, a living will, a durable power of attorney for health care decisions, or through springing powers provided for within a guardianship; and

To at any time make a complaint in accordance with K.A.R. 30-60-51 concerning a violation of any of the rights listed in this regulation or concerning any other matter, and the right to be informed of the procedures and process for making such a complaint.

How to file a complaint or grievance concerning a violation of any of these rights, or any other matter of concern, with the Executive Director of the Center. Forms are available upon request from the receptionist or concerns may be voiced verbally.

1) Complaints can be made verbally or in writing to the Executive Director or QA Coordinator via the receptionist, treatment provider or by directly calling or writing the Executive Director or QA Coordinator. The Executive Director or QA Coordinator will investigate and respond to any complaint within one week under ordinary circumstances.

2) If the client is not satisfied with the way the complaint is handled, **or** if the complaint involves the Executive Director of this Center, a verbal or written complaint should be directed to: Privacy Officer or the ELC Board President.

    a) The complaint will then be investigated by the governing body of the Center and a disposition made no later than one month following receipt of the complaint. The client will then be contacted in writing of Board action taken on the complaint. The client may be represented by counsel or any other person(s) of their choice during the process of filing a complaint or grievance.

3) In addition to the resources to address complaints noted above, complaints regarding Substance Use Disorder Treatment may be directed to Wayne Pickerell of the Kansas Department of Aging and Disability Services at Survey, Certification and Credentialing Commission, 115 E. Euclid, McPherson, Kansas 67460 or by calling 620-718-8009.

Client/Guardian Signature _____ ID Number _____ Date _____

NOTICE OF PRIVACY PRACTICES
EFFECTIVE March 21, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice; you may request a copy at any time.

Elizabeth Layton Center (ELC) provides health care services in partnership with physicians and other professionals and organizations. The following individuals follow this Notice of Privacy Practices: All individuals employed by Elizabeth Layton Center also including volunteers and students and any health care professional who examines or treats you at any Elizabeth Layton Center facility

References to "Elizabeth Layton Center (ELC)" and "we" in this notice includes each of these individuals and organizations. You will be asked to provide a written acknowledgement of your receipt of this Notice. We are required by law to make a good-faith effort to provide you with our Notice and obtain such acknowledgement from you. However, your receipt of care and treatment from ELC is not conditioned upon you providing the written acknowledgement.

If you have any questions about this Notice, please contact: **Elizabeth Layton Center, Inc./Privacy Officer**

PO Box 677/ 2537 Eisenhower Road
Ottawa, Kansas 66067-0677
785-242-3780

OR

PO Box 463/25955 W 327th Street
Paola, Kansas 66071-4920
913-557-9096

HOW ELIZABETH LAYTON CENTER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

ELC may use and disclose your protected health information (PHI) for the following Treatment, Payment and Healthcare (TPO) purposes without your express consent or authorization. We will obtain your written authorization before using or disclosing your PHI for any other purpose. You may revoke such authorization, in writing, at any time to the extent ELC has not relied on it.

Treatment. We may use your PHI to provide you with treatment. We may disclose PHI to providers, students or other personnel involved in your care. We also may disclose PHI to persons outside ELC involved in your treatment, such as other health care providers, family members, and friends.

Unless you tell us otherwise, we may leave messages on your voicemail identifying ELC and asking you to return our call or to remind you of a scheduled appointment.

Payment. We may use and disclose your PHI as necessary to collect payment for services we provide to you and/or provide PHI to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to ensure quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates. ELC provides some services through contracts or arrangements with business associates. Business associates are required to appropriately safeguard your information.

Creation of De-identified Health Information. We may use your PHI to create de-identified PHI. This means that all data items that would help identify you are removed or modified.

Uses and Disclosures Required by Law. We will use and/or disclose your PHI when required by law to do so.

Disclosures for Public Health Activities. We may disclose your PHI to a government agency authorized (a) to collect data for the purpose of preventing or controlling disease, injury, or disability; or (b) to receive reports of child or elder abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures About Victims of Abuse, Neglect, or Domestic Violence. ELC may disclose your PHI to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for Judicial and Administrative Proceedings. Your PHI may be disclosed in response to a court order, subpoena, discovery request, or other lawful process if certain legal requirements are met.

Disclosures for Law Enforcement Purposes. We may disclose your PHI to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures Regarding Victims of a Crime. In response to a law enforcement official's request, we may disclose PHI with your approval or in an emergency situation or if you are incapacitated if it appears you may have been the victim of a crime.

Disclosures to Avert a Serious Threat to Health or Safety. We may disclose PHI to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for Specialized Government Functions. We may disclose PHI as required to comply with governmental requirements (e.g.. national security or for protection of government personnel or foreign dignitaries).

Disclosure for Fundraising. We may disclose demographic information and dates of service to an affiliated foundation or a business associate that may contact you to raise funds for ELC. You have a right to opt out of receiving such fundraising communications.

Disclosure for Remunerated Treatment Communications. We may disclose PHI for the purposes of communicating treatment alternatives or health-related products or services when ELC receives payment for PHI in exchange for making the communication. You have a right to opt out of receiving such communications.

OTHER USES AND DISCLOSURES.

We will obtain your written authorization before using or disclosing your information for any other purpose not described in this notice. You may revoke such authorization, in writing, at any time to the extent ELC has not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy PHI maintained by ELC. You must complete a specific form. You also have a right to an electronic copy of your PHI. If you request copies, we may charge a reasonable fee. We may deny you access in some circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form.

Right to an Accounting of Disclosures and Access Report. You have the right to request a list of disclosures of your PHI we have made, with certain exceptions defined by law. You also may request a report indicating who has accessed your PHI maintained by ELC or its business associates in an electronic designated record set in the last three years. To request an accounting or an access report, you must complete a specific form.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your PHI for TPO. We must accept certain requests to not disclose PHI to your health plan for TPO if you have paid in full out of your own pocket for the item or service. You must complete a specific form. ELC's Privacy Officer is the only person who has the authority to approve the request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form. ELC's Privacy Officer is the only person who has the authority to act on the request. We will not ask you the reason for your request, and we will accommodate reasonable requests.

Breach Notification. We are required to provide you with written notice concerning breach of your PHI. You will receive the notice by first-class mail, unless you agree to another form of notice, or we do not have a current address for you. If you have any concerns regarding unauthorized use or disclosure of your PHI or any breach notification made by ELC, you should contact ELC's Privacy Officer.

HEALTH INFORMATION TECHNOLOGY.

ELC participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of TPO. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. You may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Or you may restrict access to all your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information. If you receive health care services in a state other than Kansas, different rules may apply. Please communicate directly with your out-of-state health care provider regarding those rules.

COMPLAINTS.

If you believe your rights with respect to PHI have been violated, you may file a complaint with ELC or with the Secretary of the Department of Health and Human Services. To file a complaint with ELC, please contact ELCs Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** ELC reserves the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.

Elizabeth Layton Center
Insurance Information/Authorization

Client Name: _____ **Client #** _____

Primary Insurance Coverage:

☐ None (Complete the Household Income Form for a Sliding Fee with proof of residence in Franklin or Miami County)

☐ Medicaid/KanCare (Medical Card) ID #: _____

☐ Other ***(the following fields are required & ELC needs a copy of the card)***

Exact Name of Insurance Company:

_____

Policy ID#: _____

Group #: _____

Coverage Effective Date: _____

Policy Holder's Employer:

_____

Union/Local name or #_____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

Policy Holder's Gender: ☐ Male ☐ Female

Policy Holder's Relationship to the Client::

☐ Self ☐ Parent ☐ Spouse

☐ Other: _____

Secondary Insurance Coverage:

☐ None

☐ Medicaid/KanCare (Medical Card) ID #: _____

☐ Other ***(the following fields are required & ELC needs a copy of the card)***

Exact Name of Insurance Company:

_____

Policy ID#: _____

Group #: _____

Coverage Effective Date: _____

Policy Holder's Employer:

_____

Union/Local name or #_____

Policy Holder's Name: _____

Policy Holder's D.O.B: _____

Policy Holder's SS#: _____

Policy Holder's Gender: ☐ Male ☐ Female

Policy Holder's Relationship to the Client::

☐ Self ☐ Parent ☐ Spouse

☐ Other: _____

☐ **This is a change in insurance that is currently on file:**

Name of Previous Insurance: _____ Coverage End Date: _____

I hereby authorize payment directly to the Elizabeth Layton Center, Inc., of insurance benefits payable under the terms of my insurance plan(s) indicated above. In addition, I authorize the release of any medical information necessary to process the insurance claim(s). I also request payment of government benefits, if any, to the Elizabeth Layton Center, Inc.

I understand that if all program requirements are met by the provider and payment is not made by the Insurance Company(ies) listed above, I may be held responsible for the charges. A copy of this authorization shall be considered as effective and valid as the original.

Date: _____ **Authorized Signature:** _____

❑ Copy of Insurance Card
❑ Copy of Driver's License/Photo ID

ELIZABETH LAYTON CENTER
For Hope and Guidance

Consent for Assessment & Treatment

Client Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in a mental health assessment at the Elizabeth Layton Center. The purpose of the assessment is to determine my current mental health needs and to develop treatment recommendations.

Understanding My Treatment. Treatment services are designed to help me, my child, or my family with concerns. Benefits from treatment may include: improvement in daily functioning, improved relationships with others, improved behavior, and/or improved mood. At times, treatment may be emotionally difficult; however, ELC staff will help guide me through this process. The Elizabeth Layton Center does not guarantee the success of any treatment.

My therapist possibly holds a masters degree or doctorate in (psychology, social work, counseling, of marriage and family therapy) but does not have a medical doctor's degree and is not authorized to practice medicine and surgery and is not authorized to prescribe drugs.

The Intake Assessment will consist of an interview, but I may also be asked to participate in psychological testing to more thoroughly evaluate my needs. I may also be asked to see additional professional staff who may participate in my evaluation and treatment.

I understand that my service provider may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing quality services to me. I understand that these discussions will be kept confidential unless I authorize that the information be released or unless allowed or required by law (e.g. in case of an emergency, necessary information may be shared with those providing emergency treatment and/or the individual(s) identified as my emergency contact(s); information regarding harm/risk of harm to self or others; and, child and elder abuse or neglect. Please also see Notice of Privacy Practices: the short version is included in the Intake packet and the long version is available upon request.).

I understand that some treatment recommendations may be addressed during the initial interview. Once the Intake Assessment is complete and a treatment plan has been formulated, I will be given the opportunity to review and discuss with my service provider the results of the evaluation, the nature of my condition, and any treatment, including alternatives to these recommendations.

I understand that this consent is **voluntary** and that I may withdraw my consent to treatment at any time.

Permission is hereby given to the Elizabeth Layton Center, Inc., to provide assessment and treatment to:

(Check One) ☐ self ☐ child ☐ other (specify) _____

Parents and Families. Therapy and psychiatric services are the most successful when both parents are involved in treatment of a child. For divorced or separated families, I understand as the parent consenting for the treatment of my child that I am responsible for notifying my child's other parent. Both parents may have access to the child's record, except in rare circumstances. If I have questions about this process, I will ask my service provider.

I acknowledge having received a copy of the **Clients Rights and Responsibilities**, and a copy of the Elizabeth Layton Center's **Notice of Privacy Practices** (as mandated by HIPAA regulations).

Medications/Laboratory Testing: If medications should be prescribed or medical laboratory tests are required as a part of my treatment, I understand that information about me will be shared with the pharmacy (or indigent program) that I obtain medications from to assist in filling and managing prescriptions for me. I am aware that prescriptions may be relayed to the pharmacy electronically through Allscripts ePrescribe. I also give my consent to release my name and my diagnosis (if necessary) for the purpose of requesting laboratory tests and obtaining results that may be needed as a part of my treatment. I understand that ELC participates in K-TRACS (prescription monitoring program) and KHIE (Kansas Health Information Exchange).

☐ **By checking this box, I agree to the terms of this Consent for Assessment and Treatment.**

☐ **By checking this box, I agree to have my information shared with T-TRACS and KHIE**

ELIZABETH LAYTON CENTER
For Hope and Guidance

Consent for Use of AI Documentation

Client Name: _____

Client DOB: _____

Guardian Name (if applicable): _____

Date: _____

I understand that, as part of providing quality behavioral health services, the Elizabeth Layton Center may use approved Artificial Intelligence (AI) technology to assist my provider with certain administrative and documentation tasks related to my care. AI is used only as a tool to support my provider and is not a substitute for the professional judgment, experience, or decision-making of my clinician.

The primary purpose of AI is to assist my provider with documentation, organization of clinical information, and other approved functions that allow my provider to spend more time focused on providing care.

I understand that my provider remains responsible for my assessment, diagnosis, treatment recommendations, documentation, and all clinical decisions regarding my care. My provider reviews all AI-assisted documentation before it becomes part of my clinical record.

ELC only uses AI technology that has been approved by the organization and is designed to protect the privacy and security of my Protected Health Information (PHI) in accordance with applicable federal and state privacy laws. My information will not be sold or used for purposes unrelated to my treatment.

I understand that, while AI technology may improve the efficiency and accuracy of documentation, no electronic system is completely without risk. As with any electronic health record or healthcare technology, there is a small risk of unauthorized access despite appropriate security safeguards.

I understand that my participation is voluntary. If I choose not to consent to the use of AI-assisted documentation, my decision will not affect my ability to receive services at the Elizabeth Layton Center. I may also withdraw this consent at any time by notifying my provider.

I have had the opportunity to ask questions regarding the use of AI in my care, and my questions have been answered to my satisfaction.

- ☐ **I acknowledge that I have read and understand the information regarding the use of Artificial Intelligence (AI) in my treatment.**

- ☐ **I consent to my provider's use of ELC-approved Artificial Intelligence (AI) technology to assist with documentation and other approved functions related to my care.**

Permission is hereby given to the Elizabeth Layton Center, Inc., to provide assessment and treatment to:

(Check One) ☐ self ☐ child ☐ other (specify) _____

Signature: _____

CONTRACT FOR SERVICES

ELIZABETH LAYTON CENTER
For Hope and Guidance

Client Name: _____ Date: _____

FEE DETERMINATION FOR CLIENTS <u>WITH</u> INSURANCE BENEFITS: Most insurance policies cover some portion of our professional fees. We do accept insurance assignments including Medicaid/KanCare and Medicare and will be glad to file claims for services directly with the insurance company. However, it is the client's responsibility to provide ELC with **<u>all</u>** the information necessary to submit claims, including a copy of the insurance card, the member identification number, the birth date and social security number of the policy holder, etc. It is also the responsibility of the client to provide ELC with updated information if the situation changes. In addition, it is the responsibility of the client to contact his/her primary care physician for a referral and/or to pre-certify treatment if required by the insurance company. Failure to do so can result in the claim being denied and the client being responsible for the full fee.

ELC will contact the client's insurance company and verify benefits prior to providing services whenever possible. However, benefit information provided by the insurance company to ELC is not a guarantee of payment. The client's insurance policy is a contract between the client and the insurance company, and the client is also expected to contact his/her insurance company to obtain a thorough understanding of the benefits. It is the responsibility of the client to provide the insurance company with all the information required to process claims for the client. ELC is not a party to that contract. Insurance claims are filed at ELC's customary charge. **If the client's insurance company does not reimburse ELC in the amount of ELC's customary charge, the client is only responsible for the deductible, co-pay, co-insurance or allowed amount. Payments are due at the time of service. If the client has a deductible to meet, ELC requires a minimum $30 payment for each service rendered to help keep balances current.** Account balances will be adjusted as payments and information are received from the insurance company.

Insurance companies including Medicaid/KanCare and Medicare have differing licensing requirements regarding providers, therapy procedures and diagnoses for which coverage applies. ELC will attempt to assign the client to a provider for whom the insurance company will pay and will advise the client as soon as possible if the insurance denies payment for services. If a provider covered under the client's plan is not available, the client will be assigned to an out of network provider and the client will be responsible for the full fee for services.

Please note that the benefits quoted by the insurance company are not a guarantee of payment and the client is responsible for payment of all services not covered by the insurance company. This information is based on medical necessity at the time services are rendered and payment of fees received. It is possible that the insurer may not cover some service providers and services of ELC including specialized testing or assessments. ELC does not take responsibility if the insurance company refuses to pay for services received at ELC.

MEDICARE ONLY: ELC requires a $20 co-pay for therapy and medication appointments to help keep balances current. Account balances will be adjusted as payments are received from the insurance company.

MEDICAID/KANCARE COVERAGE:
In some instances additional services considered medically necessary may be approved by Medicaid/KanCare. Services not deemed medically necessary by Medicaid/KanCare will be subject to cost up to the full fee rate and the client will be responsible for this payment. See following page for more information regarding full fee rates. Please consult with our billing staff and/or your service provider if you have additional questions.

CANCELLATIONS: Cancellations must be made 24 hours in advance of the scheduled appointment.

MISSED APPOINTMENTS: In the event a client no shows or cancels without 24 hour notice for two scheduled appointments in a rolling 90 day period, ELC will follow the missed appointment policy (see policy).

CRISIS SERVICES: Available by contacting the Crisis Department to schedule an appointment to meet with a Crisis Therapist when necessary.

FEE DETERMINATION FOR CLIENTS WITHOUT INSURANCE BENEFITS: The fee for clients, who reside in Franklin or Miami County and are without mental health insurance benefits, will be based on ability to pay for services. Clients will be responsible for the fee determined by policy guidelines. In order to determine "ability to pay", the Elizabeth Layton Center (ELC) has adopted a sliding fee scale which takes into consideration the resources of the family and the number of family members dependent on those resources. **Clients are required to supply proof of their gross household income and residence prior to or at the time of the intake. Without income and residency verification,** the ***sliding scale fee cannot be assessed*** and the client will be **responsible for the full fee.** In addition, clients are required to provide updated proof of household income either on an annual basis or immediately upon a change in situation.

EVALUATIONS & ASSESSMENTS: Clients must **pre-pay** for all court-ordered psychological testing, parenting assessments, and evaluations. Fees are based on time spent with the client plus time required for scoring and interpreting test results. ELC does not submit claims to insurance companies for court-ordered services unless medical necessity can be established.

FEE DETERMINATION FOR CLIENTS RESIDING OUT OF COUNTIES: Clients residing outside of the counties of Franklin and Miami may be served, if time is available. **Medication Services and Case Management Services** are **not available** for out of county residents. The client will be charged full fee unless the client has health insurance. In some instances, healthcare coverage may not pay for all or part of services. Clients who receive services, which exceed the limit deemed medically necessary by their coverage provider (e.g. Medicaid/KanCare), will be charged full fee.

FULL FEES: Intake Assessment $200; Individual Therapy $110 (16-37 minutes), $150 (38-52 minutes); and $200 (53+minutes); Family Therapy $120; Couples Counseling $75, Crisis Therapy $170 first hour $110/per 30 minutes after first hour; Group Therapy $50;
Medication Services: Medication Evaluation $270 and 15-minute Medication Check (E/M) $110-$175
Psychosocial Rehab Individual $56.72; Psychosocial Rehab Group: Adults $18.20 & Children $36.40;
Peer Support Individual $70.48; Peer Support Group $35.24; Attendant Care $27.84; Targeted Case Management $43.32; Crisis Basic $90.48; Crisis Intermediate $144.80; Community Psychiatric Support and Treatment (CPST) $132.72; SUD Intake $200; SUD Individual Therapy $110 (16-37 minutes), $150 (38-52 minutes) and $200 (53+minutes), and SUD Group $50

PAYMENT METHOD: Payment is due at the time services are rendered. Payment may be made by cash, check, money order, credit or debit card. If, after submitting claims to the insurance company, the client is responsible for more than the anticipated portion of fees, a monthly statement will be sent to the client. Failure to pay may result in unpaid balances being sent to the Kansas Setoff Program.

Contact the Billing Department at 785-242-3780 or 913-557-9096, if you have any questions or need to establish a payment plan.

FEE REDUCTIONS: Uninsured clients who are undergoing unusual circumstances which affect their ability to pay may request a temporary fee reduction. The fee reduction request form is available upon request and will be reviewed and approved or rejected by the Executive Director or designee. Client will be notified of the decision.

RESPONSIBILITY: The client (or the parent/guardian that brings the client in for services) is considered responsible for payment at the time services are rendered. ELC requires date of birth, driver's license and the social security number of the responsible party.

I agree to pay the established fee. I understand that the fee is due at the time that services are rendered. I also understand my obligation to provide necessary insurance information or proof of household income in a timely manner if the client's situation changes.

☐ **By checking this box, I agree to the terms of the Contract for Services.**

ELIZABETH LAYTON CENTER
For Hope and Guidance

Client Name: _____ Client Number: _____

Missed Appointments Policy

Participating in the treatment process is an important part of meeting your service goals. We value the time that you have reserved with us for this process, and ask that you make every effort to keep scheduled appointments. This will help assure our ability to meet the needs of all clients at Elizabeth Layton Center.

Please review and acknowledge our Missed Appointment Policy described below with your signature.

- Please **arrive on time** or slightly early for scheduled appointments.
- **Cancellations** must be made **24 hours in advance**. Please call 785-242-3780 (Franklin County) or 913-557-9096 (Miami County) and let us know your intentions for follow-up with services.
- **Cancellations** made **less than 24 hours prior** to scheduled appointment are a **missed appointment**.
- After **two (2) Missed therapy appointments** in a **rolling 90-day period**, you will **not** be able to schedule an appointment with your therapist, and will be required to complete an alternative scheduling appointment. The alternative scheduling options are:

"Same-day Scheduling"- Call the front desk to see if there are any same day appointments available with your therapy provider and attend that same day appointment. This appointment can be attended via telemedicine or in-person.

"Walk-In Appointment" – Attend a first-come-first-serve walk-in appointment for your therapy provider. This appointment can be attended via telemedicine or in-person. Therapists have a walk-in hour on Tuesdays at 2:00p.

"Engaging In Wellness Group" – Attend the therapy group called "Engaging in Wellness". This group is for adult clients only. Call the front desk for details.

24-hour crisis services will be available as needed for emergent mental health needs.

We will do our best to help you meet the Missed Appointment Policy. With your approval, our staff will attempt to **provide reminder call(s) and/or message(s) and/or email(s) about your scheduled appointments** for therapy and medication management. (Standard Messaging Rates will apply.) Please indicate below your choice in how we contact you with scheduled appointment information:

☐ Please do **NOT** remind me about my scheduled appointments.

Appointment Reminder Authorization:

☐ **YES**, I would like to receive an **Automated Reminder Call** Phone#-_____

☐ **YES**, I would like to receive **Text Message Reminder** Phone#-_____

☐ **YES**, I would like to receive an **Email Reminder** Email-_____

I have read and agree to the Missed Appointment Policy and have stated my contact preferences.

☐ **By checking this box, I am agreeing that I have reviewed the Missed Appointment Policy.**

Elizabeth Layton Center only allows one therapy appointment to be scheduled at a time.

☐ **By checking this box, I am agreeing that I understand this Elizabeth Layton Center Policy.**

ELIZABETH LAYTON CENTER

For Hope and Guidance

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This is an agreement between you, _____ and the Elizabeth Layton Center. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights: and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our receptionist or by contacting our Privacy Officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke if (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

☐ **I acknowledge that I have received a copy of the "Notice of Privacy Practices", including information about the permitted uses of my protected health information for treatment, payment and clinic operations.**

☐ **By checking this box, I agree that I have reviewed the Consent to Use and Disclose Health Information.**

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION - PCP

Printed Name of Client	Maiden Name (If Applicable)	Last 4 digits of SSN	DOB

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency:_____ **Relationship to Client::**_____

Address:_____ City:_____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

□ I do not have a PCP/ □ I prefer to not authorize exchange of my PHI with my PCP for the following reason(s):_____

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ Elizabeth Layton Center - Franklin County
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ Elizabeth Layton Center - Miami County
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION - Pharmacy

Printed Name of Client	Maiden Name (If Applicable)	Last 4 digits of SSN	DOB

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency: _____ **Relationship to Client::**_____

Address:_____City:_____ State & Zip Code: _____

Telephone: _____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
___Other-Specific Information: Current Medication List

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

□ **I do not have a Pharmacy/** □ **I prefer to not authorize exchange of my PHI with my Pharmacy for the following reason(s):**_____

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ **Elizabeth Layton Center - Franklin County**
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION - School

Printed Name of Client	Maiden Name (If Applicable)	Last 4 digits of SSN	DOB

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency:_____ **Relationship to Client:**_____

Address:_____ City:_____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS & AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

□ **Child does not attend school/□ parent/guardian prefers to not authorize exchange of PHI with school for the following reason(s):**_____

_____

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ **Elizabeth Layton Center - Franklin County**
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Revoked: □ Yes Date of Revocation:_____

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Printed Name of Client	Maiden Name (If Applicable)	Last 4 digits of SSN	DOB

I hereby authorize **Elizabeth Layton Center** to: □ **Release to** **and/or** □ **Receive from**

Individual/Agency:_____ **Relationship to Client:**_____

Address:_____ City:_____ State & Zip Code:_____

Telephone:_____ Fax (optional): _____

The following: information from my medical/clinical record may be released and/or obtained as checked (✓):

____Medical/Records; Summary of Assessment & Treatment
____Psychological/Psychiatric Records; Summary of Assessment & Treatment
____ Substance Abuse Attendance, Summary of Assessment & Treatment
____Arresting Officer's Narrative Summary (AOR), BAC and Related Court Documents
____ Appointment Information
____ Income, Payment & Insurance
____HIV Testing or Treatment or Treatment of AIDS AIDS-related conditions
____Other-Specific Information_____

All records specified above may be requested or disclosed unless restrictions are specified here:_____

_____

I understand that the information shared will be used for the purpose of: □ Treatment □ Evaluation □ Coordination of Care □ Disability Determination □ Fulfill Request From Attorney □ Other – specify reason(s)_____

I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above. This authorization to disclose information contained in my medical/clinical records may be revoked by me at any time by providing verbal or written notice, except for any information or record or portion of that record that has already been released. **Unless I revoke this authorization earlier, it will expire in: □ 3 months □ 6 months □ 9 months or it will automatically expire one year after the date it is signed by the client/guardian.**

I understand that I am not required to release confidential information in order to receive treatment. I understand that the information contained in my medical/clinical records contains (or may contain) confidential psychiatric information that may include drug, alcohol and HIV information. This information may be protected by Federal and State Law. I further understand that Elizabeth Layton Center shall only release this information to the agency or person(s) named above. I also understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed without my permission and no longer protected by those regulations.

X_____ _____
Signature of Client (age 14 or older) Date

_____
Signature of parent, guardian or legal representative | Printed Name of Representative | Specify Relationship | Date

X_____ _____
Signature of Witness Date

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general consent for the release of medical or other information is **NOT** sufficient for this purpose.

❑ **Elizabeth Layton Center - Franklin County**
Attn: Medical Records
PO Box 677
Ottawa, KS 66067
(785) 242-3780 Office
(785) 242-6397 Fax

❑ **Elizabeth Layton Center - Miami County**
Attn: Medical Records
PO Box 463
Paola, KS 66071
(913) 557-9096 Office
(913) 294-9247 Fax

ELIZABETH LAYTON CENTER
For Hope and Guidance

Date: _____

Full Name:	
Date of Birth:	
Height:	
Weight:	
BMI:	
Blood Pressure:	

Name of person completing this form: _____

Relationship to the client: _____

About Your Child: (Please Circle)

Does your child have a primary care provider for their healthcare needs? Yes No

If yes, name of provider: _____

When was your child's last visit to their primary healthcare provider? _____

Does your child attend regular dental screenings? Yes No

If yes, name of provider:_____

When was your child's last dental screening?_____

Does your child see any specialty medical providers? Yes No

If yes, name of provider: _____

Does your child work with an individual for their behavioral health needs? Yes No

If yes, name of individual: _____

Does your child have any vision problems? Yes No

If yes, please explain:_____

Does your child have any hearing problems? Yes No

If yes, please explain:

Does your child have any medical condition(s)? Yes No

If yes, please explain:

Family Medical History. Please list any serious medical conditions in your child's family (e.g. diabetes, asthma)

Are you (child) currently taking any medications? (Please Circle) **YES** **NO** **SEE ATTACHMENT**

If yes, please list what medications and for what condition:

MEDICATION	DOSAGE	CONDITION

Does your child have any allergies to any medications, food, or environmental factors? If yes, please describe:

Habits

How much daily screen time does your child have (e.g. t.v, ipad, cell phone)?