PATIENT ACKNOWLEDGEMENTS / CONSENTS

1. I agree to be evaluated by a member of the Bowen Center clinical staff. Following the evaluation, I will be asked to consent to specific treatment recommendations as stated in the treatment plan.
2. I understand these services are voluntary and that I may revoke consent at any time.
3. I understand therapy sessions are private and conversations during therapy cannot be recorded without consent from both the patient and provider.
4. I understand that Bowen Center medical staff will routinely verify that I am not receiving controlled substances from another provider via the INSPECT report **(*medication patients only).***
5. I understand that Bowen medical staff will submit prescription orders to the pharmacy that I have designated for the purpose of continued treatment. These prescriptions may include information that discloses I am a substance use patient (diagnosis, medication name). I can revoke this consent at any time unless Bowen Center has already acted in reliance on it. Expiration of this specific consent will be until the end of services or when a new consent is signed.
6. I understand that for my safety, my medication fill history may be obtained electronically from the pharmacy database to ensure thorough medication reporting.
7. I understand student nurses/interns may be involved in my treatment and I can refuse treatment that is provided by them at any time.
8. I have been offered a copy of my Bowen Center and ASPIN Rights and Responsibilities regarding services being provided. A copy of these Rights and Responsibilities will be posted in the office in which I will be receiving treatment, or I may review them on Bowen Center's website: www.bowencenter.org.
9. I have received a copy of Suicide Prevention Information. This is also available on Bowen Center's website: www.bowencenter.org ***(N/A for IPU – Patient will receive at discharge.)***
10. I have received a summary of Bowen Center's Notice of Privacy Practices. I am aware that detailed information is available upon request and is available on Bowen Center's website: www.bowencenter.org
11. I and/or the patient being admitted will be financially responsible to pay Bowen Center for any costs incurred to collect this debt, including but not limited to collection fees, interest fees, and attorney fees. I understand that some services may be court mandated. I understand also that some services may include preparation of reports, testimony, and other non-direct patient services.
12. **Financial (Payment, Charges & Billing)**
    - I understand these services will be charged at the rate discussed with me.
    - I agree to notify Bowen Center of changes that may affect my fee.
    - I understand it is required to supply written proof of financial status. Failure to provide this information in a timely manner shall disallow any discounted fees.
    - I understand that telephone consultations with the patient and/or family may be charged at the regular fee rate.
    - **I understand that payment is due at the time of service, and that all co-pays and deductibles are due at each visit.** Any other arrangements must be approved in advance.
    - I understand that I am responsible for any remaining balance after insurance has paid or if insurance does not pay.
    - I agree that in order for you to collect any amounts I may owe; you may contact me by telephone at any telephone number associated with my account. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of a dialing service, as applicable.
    - This is to advise you that unless otherwise requested, the Bowen Center will file all services with your insurance company and/or Medicare. If you request, we not bill your insurance company, you will be responsible for your entire balance.

By signing below, I acknowledge that the corresponding statements and information have been explained and reviewed with me, and I understand them. I voluntarily consent to participate in treatment.

______________________________________ ______________________________
Patient Signature   Date   Patient Printed Name

______________________________________ ______________________________
Patient's Representative Signature (if applicable)   Date   Representative's Relationship to Patient

For Office Use Only: ☐ Patient refused to sign per ____________ *(Staff Initials)*   ☐ Patient unable to sign per ____________ *(Staff Initials)*

Patient Name: ______________________
MRN: ______________________
Location: ______________________

Financial / Nominal Fee Assessment

Please answer the following questions:

1. Do you currently have active Medicaid? ☐ No ☐ Yes

(Having Medicaid or Medicare will not be used to determine eligibility for fee assistance discounts.)

2. Size of family unit: ___________________ (*Number of individuals supported by the family income: Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Bowen Center will also accept non-related household members when calculating family size.)*

3. Head of Household Name:____

4. Total annual household income Salary: $ _____________________

5. Below are the current federal poverty guidelines:

Income includes gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; public assistance; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

Household Size	200% of Federal Poverty Guidelines
1	$27,180
2	$36,620
3	$46,060
4	$55,500
5	$64,940
6	$74,380
7	$83,820
8	$93,260
	Add $9,440 for each additional person

☐ I certify I have no income.

****Supporting documentation of income is requested but not required to be eligible for the Sliding Fee Discount if you are uninsured****

My signature certifies that the total gross household income is accurate.

____ _____________________

Patient or Parent/Guardian Signature Date

Name: ____
MRN: ____
Location: ____

Medical Problems / Health Status

Check below all current or historic medical conditions:

☐ Is at risk for sexually transmitted diseases ☐ High Cholesterol ☐ Obesity ☐ Dental Problems
☐ Birth Defects ☐ Diabetes ☐ Heart Conditions ☐ Asthma ☐ Ear Infections ☐ Severe Acne ☐ Eczema
☐ Hypertension ☐ Kidney Issues ☐ Liver Issues ☐ Seizures ☐ Head Injury ☐ Positive TB Test
☐ Tuberculosis (Symptoms may include chronic cough, night sweats, fatigue, or weight loss) ☐ Shunt
☐ Medical problems:_______________ Treating Physician: _______________

☐ Has not had a physical examination within the past one year. Date of last exam: _______________
☐ Immunizations are not current. Why? _______________

Were any items checked above? ☐No ☐Yes

Staff Use Only:

***** If "Yes" is checked above, recommend that the client see a physician for a physical examination and treatment of the identified condition. Include analysis of the impact the physical condition has on his/her mental health. *****

Is there any family history of medical problems? If ***yes***, please describe.	☐No ☐Yes
Has he/she been injured in the past year (address falls, broken bones, sports injuries, etc.)? If ***yes***, describe:	☐No ☐Yes
Does he/she have any allergies? ***If yes***, list:	☐No ☐Yes
If female**,** is she currently pregnant or breast feeding?__________ Due date:_______________	☐No ☐Yes

Pain/Discomfort Evaluation

Do you have any present or recurring physical pain/discomfort? ***If yes****, please circle/select the face on the scale below that describes your child's pain.*	☐No ☐Yes

What body part?_______________ When did the problem start?_______________ How long does it last?_______________	
Is he/she receiving treatment for the identified pain? ***If yes***, name of physician treating pain:_______________	☐No ☐Yes
What activities is he/she unable to do because of pain?_______________	

Nutrition Risk Screening

Does he/she eat non-food items? (A 'Yes' response indicates moderate risk.)	☐No ☐Yes
Has his/her appetite changed that causes reason for concern? (A 'Yes' response indicates moderate risk.)	☐No ☐Yes
Does the child have food allergies or intolerances that impair his/her ability to consume adequate nutrition?	☐No ☐Yes
Is he/she, or a parent, concerned about weight? Approximate height:__________ Approximate weight:__________	☐No ☐Yes

***** If there is a "Yes" response to any of the above nutritional risks, recommend a referral. *****

Medication

Is he/she taking prescription medication(s)? ***If yes,*** complete the attached medication list.	☐No ☐Yes
Provide any other medical information that would be important to your care:	

Client Name: _______________
MRN:_______________
Service Location:_______________

Developmental Information	
Were there any difficulties with pregnancy, labor, and/or delivery? ***If yes***, please specify:	☐No ☐Yes
Were there any sleeping or eating difficulties as a newborn? ***If yes,*** please explain:	☐No ☐Yes
Were there any hospitalizations during his/her first year? ***If yes***, please explain:	☐No ☐Yes
Was he/she difficult to bowel and/or bladder train?	☐No ☐Yes
At what age did he/she begin doing the following tasks? Crawling ________________ Walking ________________ Talking/words ________________ Talking/short sentences ________________ Following simple directions to identify objects or retrieve items________________	
Is he/she ☐right handed? ☐left handed?	
Does/Did he/she have motor skill problems? ***If yes***, please describe:	☐No ☐Yes
As a toddler, did he/she often fail to respond to verbal instructions? ***If yes,*** please explain:	☐No ☐Yes
Does he/she have a history of severe or prolonged temper tantrums?	☐No ☐Yes
Does he/she become upset when things change? ***If*** yes, please explain:	☐No ☐Yes
Does he/she have problems getting along with others the same age? ***If yes***, please explain:	☐No ☐Yes
Did/Does he/she have hearing problems? ***If yes***, please explain:	☐No ☐Yes
Did/Does he/she have vision problems?	☐No ☐Yes
Did/Does he/she have language and speech problems?	☐No ☐Yes
Did/Does he/she have exceptional learning needs? ***If yes***, please check: ☐Slow learner ☐Learning disabled ☐Gifted ☐Other (please specify):	☐No ☐Yes
Does he/she receive any special education services to help with learning? ***If yes***, please explain:	☐No ☐Yes
How does he/she learn best? (Check as many as apply) ☐Hearing ☐Seeing ☐Touching ☐Doing ☐Moving ☐Repeating in words or singing ☐Other (please specify)	
Does he/she have any current developmental problems, as discussed above, that are not now being treated by a doctor? ***If yes***, what problems **are not** being treated?	☐No ☐Yes
Does he/she see a physician or go to a specialized clinic on a regular basis (e.g., neurologist, urologist, Riley Clinic, etc.)? ***If yes***, name of doctor/clinic: ______________________________ Reason:	☐No ☐Yes
Provide any other information about this child's development that would be important to his/her care:	

Signature	Date
Printed Name	Relationship

ADMISSION MEDICATION LIST

CLIENT: Please list medications prescribed by physician. **Date:**

Medication	Prescriber	Medication	Prescriber

Do you take herbal medication(s)? ☐No ☐Yes *If yes,* please list:	

Do you take non-prescription (over-the-counter) medication(s) more than twice a week? ☐No ☐Yes *If yes,* please list:	

Client Signature________________________

Medication list verified by Nurse: ***To be completed only within 180 days from date above.***

Date	Medication/Dose	Med Ed	Prescriber	Verified	Nurse Signature

C554 (06/12/09)
(Tab:P/O)

Admission Medication List
Bowen Center

Client Name____________________
MRN_________________________
Service Location________________

Bowen Center
Authorization for Communication via Text

Bowen Center recognizes the need to protect the privacy of your Protected Health Information (PHI). It is important that you understand texting is not a secure mode of communication.

If you choose to participate in text communication with Bowen Center, please note:

- Because text communications are not secure, they should contain limited information.
- For your protection, do not send personal identifiers via text messages, such as your last name, age, birth date, social security number, etc.
- Staff response to text message will not contain any protected health information.
- Texting should not be used as a means to reach staff after regular hours, on the weekends, or when staff is on leave. (This may be different for Care Navigation Clients)
- In the case of an after hours emergency, please call the Bowen Center main line at (574) 267-7169 or dial 911.

By signing below, I give Bowen Center permission to communicate with me via text. I am aware that texting is not secure, and that the confidentiality of the texts I send cannot be guaranteed. I understand and agree to the terms listed above.

____________________________________ __________________________
Client/Parent/Guardian Signature Date

____
Printed Client/Parent/Guardian Name

Client Name:____________________________
MRN:________________________________
Location:______________________________