BEHAVIORAL HEALTH PATIENT DEMOGRAPHIC SHEET

Patient Name: _____

Preferred Name: _____ Preferred Pronouns: _____

DOB: _____ Age: _____ Sex: M F

Address: _____

_____

Primary Phone: _____ Primary Email: _____

EMERGENCY CONTACTS

Primary Name: _____ Relationship: _____

Address (if different from the patient) _____

Contact # _____

Secondary Name: _____ Relationship: _____

Address (if different from the patient) _____

Contact # _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy#: _____ Group # _____

Subscribers Name: _____ DOB _____

Subscriber Relationship to Patient: _____

Insurance Company Phone # _____

Secondary Insurance: _____

Policy#: _____ Group # _____

Subscribers Name: _____ DOB _____

Subscriber Relationship to Patient: _____

Insurance Company Phone # _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Address: _____

Transportation Needs: _____

Financial Agreement and Guarantee

Please Print Date_____

Patient Name_____ Medical Record No._____

Parent's Name _____Parent's Name _____

Other Responsible Party (state relationship)_____

ASSIGNMENT OF BENEFITS

I hereby assign to Four Winds Hospitals all my right, title and interest, including benefit of payment to which I am or may be entitled from _____ insurance company under policy 1 #_____ for Insured Name_____ and from _____ insurance company under policy 2 #_____ for Insured Name_____ or from any governmental agency, other insurance carrier and/or their agents, or others who are financially responsible for the hospitalization and medical care and services rendered to me or my dependent at Four Winds Hospitals.

FINANCIAL AGREEMENT AND GUARANTEE

(I)We (jointly and severally) agree to pay and guarantee payment to Four Winds Hospitals the full and entire amount of any and all bills not paid in full by our health insurance plan(s), private or governmental, or combination of plans due to any reason including, without limitation, exhaustion of benefits, a pre-existing condition excluded from coverage, and responsibility for co-payments. I understand that all such bills are due and payable upon presentation at the Hospital's negotiated rate with my health insurance plan(s), or if I do not have health insurance benefits, at the rate I have negotiated with the Hospital. Payment may be demanded at any time from any of the undersigned, and failure to demand payment of the patient shall not be a prerequisite to the guarantor's immediate responsibility for payment. This agreement shall be governed by the laws of the State of New York as a contract deemed executed in New York and to be performed in New York. We expressly consent to the jurisdiction of New York State and federal courts and to venue in Westchester County in any action brought relating to this agreement. We agree to pay any costs and expenses incurred by Four Winds Hospitals to enforce this agreement, including reasonable attorneys' fees. This document constitutes the complete agreement of the parties. We acknowledge that we have not relied on statements, promises, or representations, oral or written, other than as contained herein. Four Winds Hospitals has accepted my check or cash for such amount and provided me with a receipt. Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days.

Four Winds Financial Agreement and Guarantee (continued)

Patient Name_____ Med. Rec. No._____

RESPONSIBILITY FOR SPECIALIZED SERVICES

(I)We understand that psychiatric and basic medical care is provided by Four Winds Hospitals. However, if specialized medical services not provided at Four Winds are indicated, we agree that the cost of such medical consultation/treatment will be (my)our responsibility. Whenever possible, Four Winds will notify the family or financially responsible person that such specialized care is indicated in advance of the visit to the medical consultant.

DENIAL OF PAYMENT BY THIRD PARTY PAYOR

Four Winds Hospitals has accepted my check or cash for 7 days of hospitalization and provided me with a receipt. **My check will be held until there is a denial of payment.** Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days. A small number of health plans provide that beneficiaries sign an addendum to this financial obligation form at the time of a denial based on lack of medical necessity. (I)we understand that (I)we will be notified by phone or in person of the denial by Four Winds Hospitals staff at the time that the Hospital is notified. If provided by my health plan, I agree to promptly execute an addendum.

If I(we) fail to execute such addendum and (I)we elect to continue to receive services at Four Winds Hospitals, (I)we agree to promptly pay for such uncovered services.

ALL PARTIES MUST SIGN

WE HAVE READ AND UNDERSTOOD THIS AGREEMENT AND ATTEST THAT ALL INFORMATION IS TRUE, COMPLETE, AND ACCURATE.

_____
Patient (if 18 or over)

_____
Parent

_____
Parent

_____
Spouse

_____
Other Responsible Party (state relationship to patient)

Four Winds HOSPITALS **DOCUMENT SIGNATURE PAGE** **CONSENT FOR TREATMENT**	Patient Name: Date of Birth:

I am requesting voluntary admission to the Partial Hospital Program and/or Intensive Outpatient. I understand that as a voluntary patient, I can choose to discontinue the program at any time for any reason. However, program staff strongly encourages patients to discuss their intention to leave the program prior to making the final decision. I have received a Patient Handbook, which includes patient rights and responsibilities, as well as the programs grievance procedure. I understand that I may go to any clinical staff member if I have questions or concerns about any of my rights or responsibilities. The risks and benefits of the Program have been fully explained to me and I am choosing to participate in the program, being fully aware of these risks and benefits.

Additionally, the prescribing of over the counter medications may occur which will allow for the administration of medications that treat symptoms such as minor aches and pain, stomach upset, cold symptoms or other minor physical complaints. All other medications which are recommended for my / my child's treatment will be reviewed with me prior to the prescribing of such medication.

☐ Yes, I consent to over the counter medications ☐ No, I do not consent to over the counter medications

I have received a copy of the following documents (check all documents given to the patient):

- ☐ Bills Of Rights
- ☐ Notice of Privacy Practices
- ☐ Patient Handbook
- ☐ An Important Message from Medicare

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I hereby consent to the taking of my photograph for identification purposes only. I understand that, upon discharge, my photograph will be kept by Four Winds Saratoga and filed in my medical record.

Patient Signature:	**Date:**
Parent or Legal Guardian:	**Date:**

I have discussed the above with the patient and his/her family (when available) and he/she has indicated an understanding of the rights guaranteed to him/her while a patient at Four Winds Saratoga.

Patient refuses to discuss above (check if applicable)	☐ Yes	☐ No
Patient refused handouts (check if applicable)	☐ Yes	☐ No

Staff Signature:	**Date/time:**

Four Winds HOSPITALS **TELEMEDICINE APPOINTMENT INFORMED CONSENT FORM**	Patient Name DOB MRN

Telepsychiatry uses two-way communication through audio and video equipment to provide mental health services to you at a distance. Telepsychiatry allows you and staff at different locations to interact and provide care without the need to travel long distance.

Expected Benefits
Telepsychiatry can be a benefit to you, when on-site services are not available because of the distance, location, time of day, or availability of resources. Some benefits to Telepsychiatry are:

- Improved access to care
- Timely services
- Improved coordination of care
- Improved treatment of care

Potential Risks
There are possible risks with the use of telepsychiatry. These risks could include:

- Delays in treatment due to equipment failure
- Poor picture and delays in the video
- Potential data transmission problems that happen in very rare instances, but could lead to a breach of your information
- A lack of information that might be available in a face to face visit but not in a Telepsychiatry session may result in errors in medical judgment

You have the right to:
If you choose to participate in Telepsychiatry services, you are given additional Client Rights including being informed of:

- What trained staff will be available to you and providing you services at the distant site and who can help in an emergency.
- How the Telepsychiatry equipment works and the purpose of videoconferencing technology.
- Who is in the room at each location during the Telepsychiatry session
- Your opportunity to decide about who will be in the room with you during telepsychiatry sessions, as well as the right to ask non-medical personnel to leave the room at any time if not needed for safety concerns.

Failure of Transmission
In the event your session is dropped as a result of transmission or equipment failure someone from the office will contact you. We would need to be sure that any alternative contact methods are encrypted and secure. This may mean a follow up in-person appointment or an additional telepsychiatry session to complete the appointment.

I understand this service is not the same as a direct provider visit, because I will not be in the same room as the provider performing the service. Parts of my treatment which involve physical tests/examinations such as taking my vital signs and blood pressure will not be completed. I understand that my telepsychiatry provider will be my local provider I would normally see in the office setting. Also,

Four Winds HOSPITALS **TELEMEDICINE APPOINTMENT INFORMED CONSENT FORM**	Patient Name DOB MRN

- I have the right to refuse or withdraw my consent to telepsychiatry sessions at any time, without affecting my right to future care or treatment.
- If my provider decides my health care can no longer be managed through telepsychiatry, services may be discontinued. Other options for my care will be discussed with me.
- Telepsychiatry sessions shall not be recorded without my consent.
- Written medical information and telepsychiatry sessions are kept confidential the same as in-person medical records.
- I agree to allow individuals other than my provider and remote provider to be present during my telepsychiatry service to operate the video equipment, if necessary. Also, if additional persons are needed for safety concerns, then my permission may not be needed.

☐ We have read the Telepsychiatry consent form to the patient/legal guardian and we witnessed the consent of telepsychiatry through the Four Winds Partial and/or Intensive Outpatient Program. The patient/family has had an opportunity to ask questions which I've answered to the best of my knowledge.

Staff1: _____ Date/Time _____

Staff2: _____ Date/Time _____

Dear Patient/Family,
Upon receipt of this form, please read through the consent above and the statement below. Sign and return to the office at your earliest convenience. Please know you have given verbal consent for your first session. After reading this form, should you change your mind please notify the staff immediately.

Four Winds Saratoga
Partial / Intensive Outpatient Program
30 Crescent Ave Saratoga Springs NY 12866

I have read and understand the information provided above regarding telepsychiatry. I have discussed the expected benefits, potential risks, as well as possible alternatives to telepsychiatry with my provider. All of my questions have been answered to my satisfaction. I hereby authorize Four Winds Partial / Intensive Outpatient to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient/Legal Guardian: _____ Date: _____

Print Name of Patient/Legal Guardian: _____

Four Winds HOSPITALS

Patient Label

FOUR WINDS PARTIAL HOSPITAL CONSENT
OBSERVATION BY DIGITAL CAMERA

I,_____ _, am the patient/parent/legal guardian of

_____ who is a patient in the Four Winds Hospitals Inpatient or Partial Hospitalization Program and is eligible for transportation by a hospital transportation service. Transportation may be to and from the Partial Program, or transported off-grounds for appointments.

I understand that cameras are installed in the transportation vehicles and that the driver and any occupants of the vehicles will be observed by the cameras. The cameras transfer a digital recording to a computer through a secure means. The camera system does not allow individual cameras to be activated or de-activated. The driver of the hospital vehicle does not have the ability to turn a camera on or off.

The digital recording will be permanently deleted periodically by the hospital. I understand that the purpose of the observation is to monitor patients' and drivers' behaviors for their safety and security. By signing this consent form I hereby give permission for my/my child/ward to be observed by a digital camera that records. I understand that the recording will not become part of my / my child's/ward's medical record, that neither I nor my/ my child have any ownership rights to the recording, that it will be deleted in the sole discretion of Four Winds, and that under no circumstances will the recording be provided to me or my child. Recordings which have not yet been deleted will not be provided to any third party except when requested by law enforcement or state regulatory agencies in compliance with state law.

I also understand that I can refuse to consent to having me/ my child/ward observed by camera and that such refusal will not affect the care and treatment me / my child receives in the Inpatient or the Partial Hospital Program. However, I understand that my / my child/ward will not be able to obtain transportation services from Four Winds Hospital and that I will need to arrange transportation to and from the PH Program for myself/ my child/ward.

Transportation for emergency medical treatment is usually provided by ambulance and not hospital vehicles, but the hospital cannot guarantee that in the event of an emergency an ambulance will always be used for transport. I understand that transportation for emergency medical treatment will be provided to me / my child/ward regardless of whether I sign this consent.

I hereby release Four Winds Hospitals from any and all claims which may arise from the use of the digital camera in transportation vehicles as set forth in this consent.

Signature: _____ Date/Time:_____

Print Name:_____ Relationship: _____

Witness Signature:_____ Date/Time:_____

Print Name:_____

Four Winds HOSPITALS Consent for Medical Emergency Treatment or Diagnostic Testing

PATIENT'S NAME	DATE OF BIRTH	DATE OF ADMISSION
PARENT/GUARDIAN NAME	PARENT / GUARDIAN NAME	
PATIENT / PARENT / GUARDIAN ADDRESS		
PATIENT / PARENT / GUARDIAN TELEPHONE (HOME)	BUSINESS	
PATIENT'S PHYSICIAN/PRIMARY CARE DOCTOR	MD TELEPHONE	
ADDRESS		

EMERGENCY INFORMATION	MEDICAL INSURANCE INFORMATION
KNOWN ALLERGIES	NAME OF INSURED PATIENT
CURRENT MEDICATIONS	EMPLOYER
	INSURANCE CO.
DATE OF LAST TETANUS BOOSTER	POLICY No. & ID No.
	Bill Four Winds for Medicare/Medicaid Patients

AUTHORIZATION

1. I authorize Four Winds Hospitals to have verbal and written communication with my/my child's pediatrician/primary care provider, if necessary, for obtaining data on medical history, immunizations, and allergies.
2. I authorize Four Winds Hospitals to provide emergency treatment and/or diagnostic testing for myself _____ or my family member _____ and to provide emergency transportation for same.
3. I authorize Northern Westchester Hospital Center, Westchester Medical Center, Saratoga Hospital/ Saratoga Care Wilton Medical Arts as appropriate, to provide emergency treatment and/or diagnostic testing for myself _____or my family member _____
4. I give consent for any diagnostic testing that may need to be provided outside of NWHC, WMC, or Saratoga Hospital/Saratoga Care Wilton Medical Arts.
5. I authorize the release of information from Four Winds Hospitals to the above named facilities for the purpose of treatment, and to Four Winds from the above facilities for the purpose of follow-up treatment.
6. I give consent for my child to go off grounds for authorized visits and be transported by and under the supervision of the Four Winds Hospitals staff. Any exceptions are stated below.
7. If a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease, my/my child's blood will be tested for HIV, Hepatitis B, and Hepatitis C to determine risk of exposure.

Exceptions: _____

I understand that in the event of any emergency situation Four Winds Hospitals (Katonah or Saratoga) will make all attempts to notify the following person(s) and the above-stated physician. In the event I am not available, I authorize Four Winds Hospitals to notify the following person(s):

NAME	Phone (AM)	(PM)
ADDRESS		
RELATIONSHIP TO PATIENT		

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ **DATE:** _____

Four Winds HOSPITALS

JONATHAN'S LAW CONTACT SHEET

For Inpatients and Outpatients: Clinical staff completes at the time of screening or admission. If the patient is the qualified person, complete Section A only. If the patient is not the qualified person, complete Section B.

SECTION A (Complete if the patient is the qualified person.)

- ☐ Patient received Jonathan's Law Information Sheet.
- ☐ Reviewed Jonathan's Law with the patient and (check one):
  - ☐ Patient verbalized an understanding of the above and had an opportunity to ask questions.
  - ☐ Patient not able to participate in above.

Patient's Signature:		Date:
Staff Signature:	Title:	Date:

SECTION B (Complete if the patient is not the qualified person.)

- ☐ Patient/qualified person received Jonathan's Law Information Sheet.
- ☐ Reviewed Jonathan's Law with the patient and qualified person and (check one):
  - ☐ Patient/qualified person verbalized an understanding of the above and had a opportunity to ask questions.
  - ☐ Patient/qualified person refused to participate in above.

The qualified person was asked if he/she wanted to be notified of incidents (complete one):

- ☐ Yes. Complete the following and remind the qualified person to provide updates to telephone numbers should the information change in the future.

Name of Qualified Person:

Address:

Phone Number:	Phone Number:

- ☐ No. The qualified person indicates that he/she does not wish to be notified of incidents.

Qualified Person Signature:		Date:
Staff Signature:	Title:	Date:

Patient Label

FOUR WINDS HOSPITAL

Consent Regarding Educational Instruction While Undergoing Treatment at Four Winds Hospital

This certification is in response to the Amendment of the Regulations of the Commissioner of Education, Part 100, Section 100.22, regarding students who receive educational services in a hospital setting.

_____ is currently enrolled in an Inpatient / Partial Hospitalization
(Patient Name)
program setting, where the student's primary need at this time is the treatment of a psychiatric illness. Four Winds Hospital provides two hours per day of instruction. The hospitalization is typically of short duration, on average of ten to 12 days. In the provider's option, the treatment needs, including therapy, outweigh the need for three hours of instruction per day, and the parent/guardian hereby consents to less than three hours per day of instruction.

_____ _____
Parent/Guardian Signature Date

_____
Print Name

LearnWell

LearnWell Academics Hospital Instruction Form

Parental Release

I _____ am the _____ of
LEGAL GUARDIAN NAME RELATIONSHIP TO CHILD

_____, ____/____/____. _____
CHILDS NAME CHILDS DATE OF BIRTH ADDRESS, NUMBER, STREET AND APT. OR SUITE NUMBER

_____, _____@_____, (____) ____-____.
CITY, STATE, ZIP CODE E-MAIL PHONE

The child is in _____ grade and attends _____ in _____. Please contact
GRADE SCHOOL SCHOOL DISTRICT

_____ at (____)-____-____ or by email at _____

CHILD HAS IEP YES ☐ NO ☐ ABSENCES THIS SCHOOL YEAR _____

I am the legal guardian of the child noted above and authorize LearnWell to obtain and exchange information with the parties indicated above for in-person academics and/or virtual academics. Additionally, I authorize LearnWell to communicate with myself, my child's school district and the location that my child is receiving treatment at to potentially coordinate and provide additional academics and counseling.

Written Consent Received From:

_____
Name/Relationship to Child

Date:

____/____/____

Verbal Consent Given From:

_____
Name/Relationship to Child

Received By:

_____
Staff Member Receiving Signature

Physician's Statement

Admitted on ____/____/____ for the following Diagnosis: _____.

The anticipated discharge date is currently: ____/____/____

PHYSICIANS INFORMATION

Physicians Name: _____ Type of Physician: _____

Hospital/Treatment Facility: _____ Unit: _____

Address: _____ Phone: _____

PHYSICIAN'S SIGNATURE: _____ Date: ____/____/____

Four Winds HOSPITALS

Social Determinants of Health Screening

Patient Label

Four Winds strives to reduce health care disparities our patients might be faced with. Please complete the following questionnaire to better understand you/your child's current circumstances:

Housing Instability

What is your living situation today?

☐ I have a place to live. ☐ I have a place to live but often worry about losing my housing.

☐ I do not have a place to live. *(i.e. shelter, park, car, abandon building)*

Details about Housing Instability? *(Unpaid rent/mortgage, mold, pests, lead paint, lack of heat, water leaks, etc.)*

Food Insecurity

Have you recently worried that your food would run out?

☐ No, not usually ☐ Yes, sometimes ☐ Yes, always

Have you recently run out of food and didn't have money to buy more?

☐ No, that has not happened ☐ Yes, within the last month ☐ Yes, within the last 6 months

Details about Food Insecurities?

Transportation Problems

Have you recently missed medical appointments, meetings, work, or from getting things needed for every day life because you did not have transportation?

☐ No, I have a car. ☐ No, I have reliable transportation *(i.e. bus, uber, friend or family)* ☐ Yes

If yes, describe concerns?

Have you used Medicaid Assisted Transportation? ☐ No, never ☐ Yes, please describe

Utility Health Needs

Has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ No, never ☐ Yes, recently

If yes, describe concern?

Interpersonal Safety

How often does anyone, including family and friends, physically hurt you?

☐ Never ☐ Rarely ☐ Often/Frequently

How often does anyone, including family and friends, threaten you or scream/curse at you?

☐ Never ☐ Rarely ☐ Often/Frequently

Details about your safety concerns?

CES Signature	Date	Time

Your therapist will review these answers and will discuss them with you during your course of treatment.

Therapist Initials

Four Winds HOSPITALS

Patient Label

FOUR WINDS HOSPITAL
QUESTIONNAIRE / SCREENING FORM
For Communicable Diseases

1. Has the patient tested positive for COVID-19 during the past 90 days?
   ☐ Yes ☐ No If yes, please indicate the date of the test_____
   (Copy of test result needed)

2. For patient with confirmed COVID-19 illness and who is recovering from the illness, please answer the following:
   ☐ Yes ☐ No Has the patient been without fever for the past 3 days without using fever-reducing medications?
   ☐ Yes ☐ No Has there been an improvement in respiratory symptoms like cough, shortness of breath?
   ☐ Yes ☐ No Has it been 10 days since the appearance of the first symptom?

3. Does the patient have any of the following symptoms, please check all that applies:

☐ Yes	☐ No	Fever/Temperature greater than 100°F or higher.
☐ Yes	☐ No	Joint pain/muscle pain/body aches
☐ Yes	☐ No	Extreme tiredness or weakness
☐ Yes	☐ No	Headache
☐ Yes	☐ No	Sore throat/cough/runny nose
☐ Yes	☐ No	Shortness of breath/difficulty breathing
☐ Yes	☐ No	Lesions or ulcers in the mouth
☐ Yes	☐ No	Nausea/vomiting
☐ Yes	☐ No	Diarrhea
☐ Yes	☐ No	Generalized rash
☐ Yes	☐ No	Conjunctivitis

4. Are there any household members recently (less than a month) diagnosed with

Measles?	☐ Yes	☐ No	If yes, when?_____
COVID-19?	☐ Yes	☐ No	If yes, when?_____
Influenza (Flu)?	☐ Yes	☐ No	If yes, when?_____

5. Was the patient exposed or was in direct contact recently (less than a month) with a person who has

Measles?	☐ Yes	☐ No	If yes, when?_____
COVID-19?	☐ Yes	☐ No	If yes, when?_____
Influenza (Flu)?	☐ Yes	☐ No	If yes, when?_____

6. Did the patient travel outside of the United States (within the last month) ☐ Yes ☐ No
   If yes, where?_____ Please indicate last day of travel:_____

Patients must provide proof of negative COVID test between 3 and 5 days of return travel.

_____	_____	_____
Signature of patient/parent or Legal guardian	Print Name	Date/Time

Four Winds HOSPITALS

FAMILY MEDICAL QUESTIONNAIRE
ONGOING MEDICAL PROBLEMS

Patient's Name:

Patient's Date of Birth:

Name of Your Child's Primary Medical Provider:	**Phone Number:**
Date of Last Visit to Your Child's Primary Medical Provider:	**Reason for this Visit:**

HAS YOUR CHILD EVER HAD:			**Comments**
Chicken Pox Illness	☐ Yes	☐ No	
Chicken Pox Vaccine	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Heart Condition or Murmur	☐ Yes	☐ No	
Head Injury	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Seizures/Convulsions	☐ Yes	☐ No	
Tuberculosis or Positive Skin Test	☐ Yes	☐ No	
Undescended Testicles	☐ Yes	☐ No	
Last Menstrual Period/Age at 1st Period	☐ Yes	☐ No	
Eye/Ear/or Speech Problem	☐ Yes	☐ No	

List any surgeries or hospitalizations your child has had:

CHECK AND EXPLAIN ANY OF THE FOLLOWING CURRENT OR ONGOING PROBLEMS:			
Weight Loss	☐ Yes	☐ No	
Weight Gain	☐ Yes	☐ No	
Sore Throat	☐ Yes	☐ No	
Frequent Headaches	☐ Yes	☐ No	
Skin Rashes/Eczema	☐ Yes	☐ No	
Difficulty Breathing	☐ Yes	☐ No	
Cough	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Diarrhea	☐ Yes	☐ No	
Constipation	☐ Yes	☐ No	
Vomiting	☐ Yes	☐ No	
Problems with Urination	☐ Yes	☐ No	
Bedwetting	☐ Yes	☐ No	
Joint Problems or Pain	☐ Yes	☐ No	

OTHER:

Please continue on to the back of the form.

DEVELOPMENTAL HISTORY (Only for patients under age 18)		
	YES	NO
1. Were there problems in pregnancy, labor, or delivery?	☐	☐
If yes, what happened?		
2. Did the mother use ☐ cigarettes, ☐ drugs or ☐ alcohol during pregnancy?	☐	☐
3. Did your child experiences any problems during the first year?	☐	☐
If yes, please describe.		
4. Do you believe your child's development was normal?	☐	☐
If no, why?		
5. At what age did your child first walk? At what age did your child first use words correctly?		

MEDICATIONS/ALLERGIES
6. What medication(s) is your child currently taking?
7. Is your child allergic to anything? Yes ☐ No ☐
If yes, what?

MEDICAL HISTORY	
8. Do you believe your child is healthy? Yes ☐ No ☐	
If no, why?	
9. Is your child's immunizations (shots) up-to-date? Yes ☐ No ☐ Does your child attend school in NYS? Yes ☐ No ☐ N/A ☐	
10. Has your child ever been hospitalized overnight or longer? Yes ☐ No ☐	
If yes, when and for what reason?	
11. Your child's dentist name is:	12. Date of last dental check-up:

TB RISK FACTOR SCREENING			
1) Any history of foreign of birth or travel greater than a three month stays in a country with higher risk of TB than the USA?	☐ Yes	☐ No	If so, which country or countries:
2) Any history of close contact with a person diagnosed with active TB?	☐ Yes	☐ No	Relationship: When:
3) Any current symptoms of TB (i.e., cough greater than two weeks, unexplained weight loss, night sweats or bloody sputum).	☐ Yes	☐ No	If yes, give details:

Signature:	Relationship to Patient:		Date:
Physician/NPP/FNP Signature:	Title:	Date:	Time:

FOR CLINIC USE ONLY

Date:_____

Time:_____ AM/PM

Reviewed by:_____

Four Winds HOSPITALS

MEDICATION QUESTIONNAIRE

Name:

Date:

Date of Birth:

Generic Name	Trade Name	Helpful	Not Helpful	Current Use	History of	Adverse	Patient, Parent, Guardian or Physician/NPP Comments
MOOD STABILIZING AGENTS/AED's							
Carbamazepine	Tegretol, Tegretol XR, Carbatrol, Epitol, Equetro						
Fluoxetine/Olanzapine	Symbyax						
Gabapentin	Neurontin						
Lamotrigine	Lamictal, Lamictal XR, Lamictal ODT						
Levetiracetam	Keppra, Keppra XR						
Lithium	Eskalith, Eskalith CR, Lithobid						
Oxcarbazepine	Trileptal						
Pregabalin	Lyrica						
Tiagabine	Gabitril						
Topiramate	Topamax, Trokendi XR, Qudexy XR						
Valproate	Depakene, Depakote, Depakote Sprinkles, Depakote ER, Valproic Acid, Stavzor						
PSYCHOSTIMULANTS							
Amphetamine	Adzenys ER, Adzenys XR-ODT, Dyanavel XR, Evekeo, Evekeo ODT						
Amphetamine Salts (Mixed)	Adderall, Adderall XR, Mydayis						
Armodafinil,	Nuvigil,						
Atomoxetine	Strattera						
Dexmethylphenidate	Focalin, Focalin XR						
Dextroamphetamine	Dexedrine, Dextrostat, ProCentra, Zenzedi						
Lisdexamfetamine	Vyvanse						
Methylphenidate	Ritalin, Ritalin SR, Ritalin LA, Concerta, Metadate ER/CD, Methylin, QuilliChew ER, Quillivant XR, Adhansia XR, Aptensio XR, Cotempla XR-ODT, Jornay PM, Relexxii						
Methylphenidate Transdermal Patch	Daytrana						
Modafinil	Provigil						
Pemoline	Cylert						
Solriamfetol	Sunosi						
SEDATIVE/HYPNOTICS							
Chloral Hydrate	Noctec						
Eszopiclone	Lunesta						
Flurazepam	Dalmane						
Ramelteon	Rozerem						
Suvorexant	Belsomra						
Temazepam	Restoril						
Triazolam	Halcion						
Zaleplon	Sonata						

Four Winds HOSPITALS

MEDICATION QUESTIONNAIRE

Name:

Date:

Date of Birth:

Zolpidem	Ambien, Ambien CR, Intermezzo, Edluar, Zolpimist						
OTHER							
Benztropine	Cogentin						
Clonidine	Catapres, Kapvay						
Cyproheptadine	Periactin						
Dextromethorphan/ Quinidine	Nuedexta						
Diphenhydramine	Benadryl						
Doxylamine	Unisom						
Guanfacine	Tenex, Intuniv						
Prazosin	Minipress						
Propranolol	Inderal						
Trihexyphenidyl	Artane						
HERBAL PREPARATIONS							

☐ I am unable or unwilling to complete this form.

☐ I have completed this form to the best of my ability.

Signature of Patient/Parent/Guardian:

Date:

☐ Reviewed in person with the patient.

☐ Reviewed over the phone with the parent/guardian of the patient.

☐ Reviewed in person with the patient and / or parent/guardian of the patient.

Signature of Psychiatrist/NPP:

Date/Time:

INSTRUCTIONS FOR COMPLETEING THE ATTACHED RELEASES

Attached are RELEASE OF INFORMATION FORMS. These forms allow FWS PHP to communicate with your child's community providers for continuity of care.

Please complete one release of information form for each of the following:

1. Patient's Insurance Company
2. Patient's Emergency Contact (Parent/Guardian)
3. Patient's Therapist
4. Patient's Psychiatric Provider
5. Patient's Primary Care Physician
6. Patient's School
7. *ANY* other collateral contacts (Step-Parents, other family members-that will be involved in treatment, CPS, Probation, Care Management etc.)

**PLEASE MAKE SURE RELEASES ARE FILLED OUT WITH FULL NAME- COMPLETE ADDRESS & PHONE NUMBER

Four Winds HOSPITALS

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151
Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Fax: (518) 580-1514
Partial Fax (518) 581-2535

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: Most recent hospital admission corresponding to date below.

Unless a period is specified, the information below will be exchanged from the most recent hospital location.

Or ☐From Date: _____ To Date: _____

Below is common information Four Winds might share with or request from the person(s) above. To better serve you, Four Winds will always practice the minimum necessary to meet the need at hand.

- Diagnosis
- Dates of admission and/or discharge
- Assessments/Psychiatric Assessment
- Progress Notes
- Discharge Summary/Instructions
- Psychological Testing
- Psychosocial Assessment
- Medical: H&P, Labs, EKG, other Medical Information
- Applications
- Educational Summary / Materials / Verbal Academic Reports
- HIV-related information, if applicable
- Verbal/Written Communication for Discharge

☐ I choose to define how my information is shared with my provider/educational facility.

Other (specify): _____

This information will be used for the following purpose(s):

Evaluation and Continuing Treatment / Coordinating Care
Educational Placement / Other Educational Concerns / Billing School District for Education
Legal//Social Servicesif applicable (i.e. County services, PINS, probation, etc.)

Four Winds Hospitals is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date

Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information	
	Title	Date Released

5/2025

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City, State, Zip:

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