



## FINANCIAL POLICY

Thank you for choosing us as your psychiatric provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

*All patients must complete our INFORMATION FORMS before seeing the doctor. FULL PAYMENT is due at time of service. We accept cash, checks, visa or MasterCard.*

### REGARDING INSURANCE:

Our policy varies according to type of insurance. Unless your insurance is one in which we accept co-pays, we require payment in full at time of service. You will be given a receipt in which you can file the insurance. If we are not a contract provider with your carrier, you are responsible for full payment. Deductibles will deny claims. If you have a calendar year deductible, you are responsible in paying each visit in full until you have met that obligation with the carrier. Co-payments are to be paid each visit. Please notify the office if you have a change in coverage. Authorizations for your first visit are your responsibility.

### USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients, and we charge the usual and customary rate for our area. You are responsible for payment, regardless of any insurance companies arbitrary determination of usual and customary rates or non-charges.

### MISSED APPOINTMENTS:

Unless cancelled, at least 24 hours (business day) in advance, our policy is to charge the normal office visit rates, as your insurance will not pay for missed appointments. We do try to call you a day prior to confirm your appointment, but please realize that this is only a courtesy call. You are ultimately responsible for remembering your appointment day and time. Please help us serve you better by keeping your appointments.

### STATEMENT OF ACCOUNTS:

Each visit, your check out receipt will show whether there is a balance due. Insurance sometimes take a while to collect. The office staff will notify you at your visit if there is a balance due.

Please let us know if you have any questions or concerns. I have read the policy and agree to the terms.

\_\_\_\_\_  
(Signature of Patient or Responsible Party)

\_\_\_\_\_  
DATE

\*\*\*\*\*

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

## **SEE COPY IN OFFICE LOBBY**

**\*\* You May Refuse To Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read or received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

### For Office Use Only

\_\_\_\_\_  
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- \_\_\_ Individual refused to sign
- \_\_\_ Communications barriers prohibited obtaining the acknowledgement
- \_\_\_ An emergency situation prevented us from obtaining acknowledgement
- \_\_\_ Other (Please Specify)

# Child and Adolescent Patient History Form

Name (First Middle Last): \_\_\_\_\_

Gender (male/female): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mother's Name (First Middle Last): \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Contact Information: Phone Numbers - Home (\_\_\_\_) \_\_\_\_\_

- Cell (\_\_\_\_) \_\_\_\_\_

- Work (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Father's Name (First Middle Last): \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Contact Information: Phone Numbers - Home (\_\_\_\_) \_\_\_\_\_

- Cell (\_\_\_\_) \_\_\_\_\_

- Work (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## SOCIAL HISTORY

Mother's Marital Status: \_\_\_\_\_

Father's Marital Status: \_\_\_\_\_

This child lives with: \_\_\_\_\_

Other children in the family:

Date of Birth Name

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is there any history of Abuse (Physical/Sexual/Emotional): Y/N

Is this child/adolescent sexually active: Y/N

Has this child/adolescent ever had interactions with the legal system: Y/N

Arrests, Court Appearances, Community Service

Are there any problems with Alcohol, Tobacco or Illegal Substances Y/N

## EDUCATION

Current Grade in School: \_\_\_\_\_

Has this child/adolescent had to repeat an academic year: Y/N

Have there been any disciplinary problems in school: Y/N

Suspensions, Detentions, Expulsions, Truancy

Is there any history of Learning Disabilities: Y/N

Has this child/adolescent ever received any Special Education services: Y/N

**MEDICAL HISTORY**

Does this child/adolescent have any history of :

Chest pain or heart problems Y/N

Seizures Y/N

Operations/Surgeries Y/N

Head injuries/loss of consciousness Y/N

Frequent dizziness/light headedness/fainting Y/N

Frequent headaches Y/N

Hospitalizations Y/N

Other ongoing medical issues Y/N

Please List: \_\_\_\_\_

Reaction to drugs or food (allergies) Y/N

Please List: \_\_\_\_\_

List all medications currently taken

Medication Dose Date Started Response

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**DEVELOPMENTAL HISTORY**

Any problems with pregnancy or delivery: Y/N

Any problems with development or reaching milestones:

Growth (Height/Weight/Head Circumference) Y/N

Walking/Crawling/Moving/Coordination Y/N

Speech/Talking Y/N

Bowel/Bladder function Y/N

Social Development/Interaction Y/N

Hearing/Vision Y/N

Onset of Puberty Y/N

**FAMILY HISORY**

Is there any family history of

Bipolar Disorder Y/N

Depression Y/N

Anxiety Y/N

Schizophrenia Y/N

ADD/ADHD Y/N

Seizures Y/N

Chest pain or heart problems Y/N

Alcohol or drug problems Y/N

Mental Retardation or Autism Y/N

Other Mental Health Problems Y/N

**SOCIAL INTERACTIONS**

This child/adolescent:

Gets along with others the same age Y/N

Gets along with adults Y/N

Easily makes friends Y/N

Is able to keep friends Y/N

Has problems with peer pressure Y/N

Has appropriate social skills Y/N

Has problems with aggression (fights/threats) Y/N

Is destructive of property Y/N  
Steals Y/N  
Lies Y/N  
Often loses temper/tantrums Y/N  
Often argues with adults Y/N  
Actively defies/refuses to comply with rules Y/N  
Does things to deliberately annoy others Y/N  
Blames others Y/N  
Often touchy or easily annoyed Y/N  
Often angry or resentful Y/N  
Often spiteful or vindictive Y/N

### **ATTENTION**

This child/adolescent often:

Fails to give close attention to details or makes careless mistakes Y/N  
Has difficulty sustaining attention Y/N  
Does not seem to listen when spoken to directly Y/N  
Does not finish tasks Y/N  
Has trouble organizing Y/N  
Avoids tasks that require sustained mental effort Y/N  
Loses things Y/N  
Forgets things Y/N  
Is easily distracted Y/N

### **HYPERACTIVITY/IMPULSIVITY**

This child/adolescent often:

Fidgets or squirms Y/N  
Has trouble sitting still Y/N  
Runs or climbs excessively Y/N  
Has difficulty doing things quietly Y/N  
Has excessive energy Y/N  
Talks excessively Y/N  
Blurts out answers Y/N  
Has difficulty waiting Y/N  
Interrupts or intrudes Y/N

### **MOOD/ANXIETY**

This child/adolescent often:

Has mood swings Y/N  
Is unhappy/sad Y/N  
Has low self esteem Y/N  
Has no energy/motivation Y/N  
Does not like change/wants things just right Y/N  
Easily frustrated or overwhelmed Y/N  
Nervous/worrying/fearful Y/N  
Does things over and over Y/N

### **HABITS**

Are there any problems with  
Sleep Y/N  
Appetite/Eating/Nutrition Y/N  
List Hobbies and Interests:

