Child/Adolescent Information Form

Patient Information

Child's Name: _____ Date: _____

Sex: Male◯Female◯ Date of Birth: _____ Age: _____

Address:

_____

City: _____ State: _____ Zip: _____

Home Telephone: _____ May we leave a message? Yes ☐ No ☐

Work Telephone: _____ May we leave a message? Yes ☐ No ☐

Cellular Telephone: _____ May we leave a message? Yes ☐ No ☐

Work E-mail: _____ May we send a message? Yes ☐ No ☐

Home E-mail: _____ May we send a message? Yes ☐ No ☐

Name of legal guardian: _____ Relationship to Child: _____

Is this child: _____ Your biological child _____ Adopted _____ Foster Child

Does legal guardian have: _____ Sole custody _____ Joint custody _____ Physical custody

Emergency Contact (Name & Number): _____

Family Information

Please list all persons living in the child's home:

Name Sex Age Date of Birth Relationship Occupation

_____

_____

_____

_____

_____

With which parents does this child live?

____ Both ____ Mother only ____ Father only ____Neither parent

If neither, this child lives with: ____ Grandparent ____ In foster care ____ Other

Please list other immediate family members not living in the child's home:

Name Sex Age Date of Birth Relationship to Child Occupation Phone

_____

_____

_____

Education Information

Name of School: _____ Current Grade: _____

Name of Main teacher: _____

Has testing been completed by the school? _____ If yes, Date: _____

Is child in any special classes or special education services? _____ If yes, please explain:

_____

Has your child ever repeated a grade? Yes◯No◯ If yes, list grade(s) and explain why: _____

_____

List the grades your child earned in each subject on their last report card:

_____

_____

Please summarize your child's progress (e.g. academic, social, testing) within each of these grade levels:

Preschool: _____

_____

Kindergarten: _____

_____

Grades 1-3: _____

_____

Grades 4-6: _____

_____

Grades 7-12: _____

_____

Medical Information

Which of the following has your child had? Please note age, complications, and frequency.:

Hospitalizations _____
Surgery _____
Allergies _____
Ear infections _____
Anemia _____
Bedwetting _____
Stool soiling _____
Staring spells _____
Seizures _____
Epilepsy _____
Arthritis _____
Language problems _____

Frequent falls _____
Vision problems _____
Hearing problems _____
Asthma _____
Loss of consciousness _____
Headaches _____
Head Trauma _____
Tics _____
Sleep problems _____
Diabetes _____
Speech problems _____
Appetite problems _____

Other _____

Current Medications: _____

Physician(s): _____ Date Last Seen: _____

Early Developmental Milestones

Were developmental milestones within normal limits? Yes◯No◯

If no, please indicate at what age your child first accomplished the following:

____ Sitting without assistance
____ Walking without assistance
____ Crawling
____ Using single words (e.g. mama, dada, ball, etc.)
____ Putting two or more words together
____ Bladder training, day & night
____Bowel training, day & night

Parent Behavior Management Methods

How do you manage your child's misbehaviors?

To what extent are you and your spouse consistent with respect to disciplinary strategies?

Child's Psychological & Social Structures

Below is a list of areas in which some children may have problems. Please briefly describe any problems your child is having in these areas:

School Problems (e.g., not doing homework, doesn't want to go to school, failing grades, having trouble learning, not paying attention, etc.):

Peer Problems (e.g., picking on others, is picked on by others, hangs around with the "wrong" crowd, fighting, doesn't have any friends, too shy, etc.):

Family/Home Problems (e.g., parents separated/divorcing/divorced, death in family, stress in home, doesn't get along with family member(s), wets the bed, etc.):

Behavior Problems (e.g., refuses to do chores, curfew problems, talks back, cruel to animals, has set fires, is defiant, temper tantrums, smokes cigarettes, drinks alcohol/takes drugs, etc.):

Mood Problems (e.g., seems angry a lot, sad/depressed, cries easily, many fears, irritable, seems in own world, etc.):

Vocational Problems (e.g., disciplinary actions, probation, termination, etc.):

Religious/Church Problems:

Other (has been sexually molested, developmental delays, is mentally handicapped, has physical handicap(s), problems with eating, etc.):

Have you ever sought help for these problems before? If so, please list when, where, and by whom your child was seen:

Have you ever sought help for other problems before, such as psychological or psychiatric services, evaluations for developmental/learning problems, etc.? If so, please list when, where, and by whom your child was seen:

Has you child ever received any medication for his/her behavior or emotional problems?

Yes ◯ No ◯

If yes, what type of medication did he/she take, what dosage, and for how long?

Has either biological parent ever been treated for a psychological/psychiatric problem? If so, for what, when, and by whom?

Are there any legal issues for any of the child's family members?

What are your primary concerns?

What are the goals you hope to achieve in treatment?

Who referred you, or how did you find out about our practice?

Please include any additional information you believe will be helpful:

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CONSENT FOR CARE

I, the patient or patient's legal representative, hereby grant permission to insights mental health & wellness to perform such assessments and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations. I understand that I am consenting and agreeing only to those mental health services that the Provider is qualified to provide within the scope of the Provider's or his/her direct supervisor's license, certification and training.

I am aware that the practice of mental health counseling is not an exact science and that no guarantees or promises have been made to me as to the result of treatment.

Patient Signature: _____ **Date:** _____
(or patient's legal guardian if patient is a minor) (Electronic Signature)

Patient Printed Name: _____

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HEALTH INSURANCE INFORMATION

*In order for claims to be submitted to your health insurance company the following information **must** be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).*

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____

Insurance Company Telephone: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

*****Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____

THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME HEALTH INSURANCE IS ISSUED.

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____

Insurance Company Telephone: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

*****Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____

THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME HEALTH INSURANCE IS ISSUED.

ASSIGNMENT OF BENEFITS

I hereby assign to insights mental health & wellness, my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid, in my name or on my behalf. I further authorize payment of benefits directly to insights mental health & wellness. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by insights mental health & wellness.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

Patient Signature: _____ **Date:** _____
(or patient's legal guardian if patient is a minor) (Signed Electronically)

Patient Printed Name: _____

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

You are not required to give this authorization. However, claim charges denied due to a failure to provide requested documents (due to a lack of authorization) will be the responsibility of the patient.

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that insights mental health & wellness reserves the right to change their notices and practices, and that I will notified if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that insights mental health & wellness has already taken action in reliance thereon. I also understand that insights mental health & wellness staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize insights mental health & wellness to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.*

**The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.*

Patient Signature: _____ **Date:** _____
(or patient's legal guardian if patient is a minor) (Signed Electronically)

Patient Printed Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & POLICIES, OFFICE POLICIES & PROCEDURES, AND GUARANTOR FEE SCHEDULE

As required by federal legislation, insights mental health & wellness is required to provide you with a copy of our Notice of Privacy Practice and document your receipt. You may waive your right to be provided with this Notice of Privacy Practice.

_____ I have received a copy of the Notice of Privacy Practices and Policies: In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

_____ I have waived my right to be provided a copy of the Notice of Privacy Practice.

_____ I have received a copy of insights mental health & wellness' Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

_____ I have received the Guarantor Fee Schedule and understand that if my services are not covered by my insurance carrier, that I am responsible for payment.

Patient Signature: _____ **Date:** _____
(or patient's legal guardian if patient is a minor) (Electronically Signed)

ELECTRONIC MEDIA/SOCIAL MEDIA POLICY

E-mail – Electronic mail will be used only for administrative communication, such as checking/arranging appointments or the communication of basic information. It will not be used to communicate therapeutic/highly personal information.

Texting – Text messages will be used only for administrative purposes, such as scheduling or changing appointments.

Social Media – In order to maintain privacy and confidentially our clinicians cannot follow or connect with any client on Facebook, Twitter or other social media outlets.

All client data stored in our database is encrypted. Text and e-mail messages are additionally protected by passwords.

Please check below if you wish to receive communication via e-mail or text message following the guidelines outlined above.

_____ I would like to communicate via the e-mail address: _____

_____ I would like to communicate via text to the following number: _____

I understand that I am responsible to communicate any changes in the above information.

Patient Signature: _____ **Date:** _____
(or patient's legal guardian if patient is a minor) (Signed Electronically)