Adolescent Patient Registration

I. Patient Information: Date: _____

A. **Basic Demographic Information**:

Name: _____
Last First Middle

Identified Gender: _____ Age: _____ Date of Birth: ____/_____/_____ Social Security #: _____-____-_____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Parent E-mail: _____ Work Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

B. **Family Life**:

1. Name of Parent/Guardian:	Relationship to Child:
Home address:	Date of Birth:
	Home Phone:
Occupation:	Cell Phone:
Employer:	Work Phone:
2. Name of Parent/Guardian:	Relationship to Child:
Home address:	Date of Birth:
	Home Phone:
Occupation:	Cell Phone:
Employer:	Work Phone:
3. What is the parents' relationship status?	
With whom does the child live?	
Who has legal custody of the child?	
Who is responsible for payment of the bill?	
Social Security # of Guarantor/Payer - -	

4. Please list all members of the child's immediate family and/or people living in his/her home.

Name	Age	Relationship	Occupation

II. Financial Information:

A. What method of payment will be used to pay for services provided? (Initial as indicated.)

____I am paying completely out-of-pocket.
____I am using my health insurance benefits.

Health Insurance Company: _____

Name of Policy Holder: _____ Date of Birth: _____/_____/_____

Relationship to patient: _____

Insurance ID#: _____ Group#: _____

Employed by: _____

B. Assignment and Release:

___ If choosing to self-pay:
I understand I am financially responsible for all services, charges and fees.

___ If using health insurance:

I hereby authorize my insurance benefits to be paid directly to *Poehailos, Dupont & Associates, PLC* for services rendered. I authorize the release of any information as required by my insurance company or other reimbursing agency. I understand I am financially responsible for the charges not covered by my insurance company.

Signature of Guardian/Guarantor: Date:

C. **Contract for Payment:** I understand that Poehailos Dupont and Associates requires a credit card on file for fees not covered by my insurance and that I will be contacted by the intake coordinator prior to my first appointment to provide this information.

_____ I authorize my credit card to be billed for all copays, ancillary charges, fees and services rendered that are not covered by my health insurance benefits at Poehailos, Dupont & Associates, PLC.

Signature of Guardian/Guarantor: Date:

Parent Questionnaire for Child/Adolescent Intake

Today's Date: _____

Child's name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Identified Gender: _____

Name of person completing questionnaire: _____

Relationship to child: _____

I. Initial Thoughts:

A. Briefly describe your reason for seeking services.

B. Who referred you to us?

C. What are your goals/hopes for treatment?

II. Previous Mental Health Treatment:

A. Does your child have any history of mental health concerns (e.g., depression, anxiety)? If so, please describe.

B. Has your child ever received counseling, psychological or psychiatric treatment? If so, please include names of clinicians, dates of treatment and nature of the problem(s).

C. Has your child ever been in a hospital for mental health/emotional problems? If so, when and where?

D. Is your child receiving services at any other local agencies (e.g., tutoring, speech therapy)? If so, please list the agency and type of service.

E. Has your child ever been on medication for emotional/behavioral problems? If so, please complete:

Date	Medication	Dosage

F. Has your child ever completed a psychological evaluation or educational assessment? If so, please complete: ***Please include copies of any reports obtained as a result of prior assessment.**

Date	Clinician/Specialist	Diagnosis/Intervention

III. Medical History:

A. Who is the child's current primary care physician?
Name:
Address: Phone
Number:

B. What are any current (or significant past) medical problems for which the child has been treated?

C. What medications (prescription or non-prescription) is the child currently on?

Date	Medication	Dosage

Any medication allergies?

Any other allergies?

D. Has your child ever had to undergo surgery? Sustained any significant injuries (e.g., head injury, broken bones)? Lost consciousness? Had a seizure? If so, describe.

E. Were there any problems during pregnancy or delivery? Were developmental milestones met on time?

F. Does your child smoke? Do you know of/ suspect drug or alcohol use?

G. Is there a family history of medical or mental health problems? Please describe.

H. Is there any other medical information you feel is important?

IV. Educational History:

A. What is the child's current school? Grade?

B. Who is the child's primary teacher?

C. Who is the child's guidance counselor?

D. What schools has the child previously attended?

Date	School	Grade(s)

E. Does your child receive special education services? Have a 504 Plan or an IEP*? Has s/he/they had to repeat any grades? If so, describe. ***Please include copies of any IEP or 504 Plan, past and present.**

F. Is there a family history of learning or school problems? If so, describe.

V. Psychosocial Information:

A. Please list any significant individuals, who do not live in the home, who are involved in the child's life. Include step-parents, older siblings, step- or half-siblings, grandparents, etc.

Name	Age	Relationship

B. Spiritual Life:

How important is Spirituality/religion in the child's life? ____ Very _____ Somewhat ____Not at All

a. If s/he/they belong to a religious organization, what is your denomination?

b. What facility/church do s/he/they attend?

c. Who is the child's spiritual leader/pastor? Youth leader?

C. Has the child ever been involved with the law? If so, describe.

D. What do you consider to be the most significant stressors the child has had to face in his/her/their life? Has s/he/they had to face abuse, death of a loved one, peer ridicule, separation/divorce?

E. Do you have any concerns about the child's friendships or relationships with peers? If so, describe.

F. Do you have any concerns about the child's relationships with family members? If so, describe.

G. Do you have any concerns about the child's behavior at school or home? If so, describe.

H. Please list some of the child's special interests or hobbies.

I. Please list some of the child's strengths and positive qualities.

VI. <u>Suggestions and Comments</u>:

A. How did you hear about us?

B. Do you have any suggestions/comments regarding this form and/or the registration process?

Thank you for the time and attention you have devoted to this form. It will help us to better serve you.

INFORMED CONSENT

I certify that I have read and accept the above ***Patient Information*** regarding *PDA*'s philosophy and policies/procedures. I understand that it is my responsibility to ask any questions that I may have of my clinician before signing. I understand that we will begin with an assessment of my family's needs and that neither *PDA* nor I are under any obligation to continue with treatment from that point. If we do decide to enter into a treatment relationship, that relationship may be terminated at any point for reasons that my clinician would discuss with me, including failure to comply with treatment recommendations and failure to pay bills. Before terminating the relationship, efforts would be made to refer me to an alternative provider if I don't have one available. I further understand that mental health is not an exact science and that no guarantee can be made as to the result or success of my treatment. I understand that treatment involves a large commitment of time, money and energy. It will require a high level of dedication on my part, and may cause me/my family to experience many intense feelings, some of which may be painful. I understand that treatment often involves making significant changes and that every change potentially has both positive and negative effects. I understand the potential benefits and risks involved in seeking mental health treatment and am willing to proceed at this time. I understand that I can discuss any questions or concerns that I have with my clinician at any point. I have received a personal copy of this document for my reference.

I have also reviewed, agreed to, initialed, and signed the accompanying ***Summary of Financial Responsibility*** document.

Parent/LegalGuardian/Guarantor

Date:

Witness

Date:

Poehailos, Dupont & Associates, PLC

SUMMARY OF FINANCIAL RESPONSIBILITY

Unless other arrangements are made, **payment for sessions is due at the time of the session** (either **full fee** if you are paying privately, or your **co-payment** if we are billing your insurance company). Failure to pay at the time of service will result in an Administration Fee of $5.00. Fees are reflected on the ***Fee Schedule*****,** which is included in the intake packet available on our website or in the office.

Insurance is billed as a service to our patients; however, insurance companies do not guarantee payment and if insurance payments are not received **within 90 days** of service**, responsibility for payment switches to the guarantor.** Office staff and your clinician are available to discuss payment issues with you.

Please review and initial the following:

_____ I understand that insurance may be filed for me, but that I am ultimately responsible for payment of fees regardless of insurance coverage.

_____ I authorize the release of medical information required to process insurance claims and/or to complete Treatment Plans/Reviews required by insurance or managed care companies.

_____ I authorize payment from my insurance company to be made directly to the practice.

_____ I understand that I am responsible for informing the practice of changes in my insurance.

_____ I understand that I am responsible for obtaining proper (pre)authorization from my insurance company to use mental health benefits. I accept responsibility for payment if authorization is not obtained.

_____ I understand there may be a *Report Preparation* fee involved in my clinician completing a Treatment Plan or a *Telephone Consultation* fee involved in my clinician communicating with my insurance/managed care company.

_____ I understand that most insurance companies only reimburse for face-to-face services and that I am responsible for payment of any Ancillary Services requested/utilized during the course of treatment.

_____ I understand that I may be billed for any missed appointments unless I call to cancel at least 24 hours before my scheduled appointment.

_____ I understand that mailed, monthly bills are due at the time of receipt. Any bill not paid within the month of the date of billing will have an interest charge of 1% added to the bill, unless other arrangements are made.

_____ I understand I will be charged an administrative fee of five ($5.00) dollars if I do not pay my copay at the time of service.

Signed **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have reviewed, been provided with the opportunity to receive, or received a copy of Poehailos, Dupont & Associates Notice of Privacy Practices.

Signature of Patient or Guardian Date

Name of Patient (if a minor)

Adolescent Informed Consent Form

The purpose of meeting with a psychotherapist is to get help with problems or processes that are bothering you or interfering with being successful in important areas of life. You may have asked to meet with and talk to a therapist or this could have occurred because your parents, teachers, doctor or someone else has concerns about you. The process of therapy involves getting to know your perspective on these difficulties or predicaments in your life, developing an understanding of the nature of the difficulties, and generating better ways to cope with or manage those difficulties. Sometimes the predicament will disappear altogether, but other times learning to manage or cope with difficulties is a good outcome.

Sometimes these difficulties will include topics you do not want your parents or guardian to know about. For most people, knowing that what they say will be kept private helps with disclosing thoughts, feelings, and perceptions and to have more trust in their therapist. As a teenager, you have certain rights to privacy that are not equal to those of an adult (the legal definition of which is 18 years old), but privacy, also called confidentiality, is a critical part of effective psychotherapy. *As a general rule, information you share in therapy sessions is confidential, unless you give consent to disclose certain information.* However, there are exceptions to this rule that are important to understand prior to starting with the therapy process. In some situations it is required by law or professional guidelines that information discussed in therapy has to be disclosed. Some of those situations are described below. Most involve your protection and the protection of others from the potential to be hurt or harmed.

1. If you report having a plan to harm yourself, based on the evaluation of that plan, confidentiality can be broken in order to protect you from harming yourself.

2. If you report having a plan to harm someone else, based on the evaluation of that plan, confidentiality can be broken in order to protect the person you intend to harm.

3. If you are involved in activities that could cause harm to yourself or someone else, even if you do not *intend* to harm yourself or someone else, based on the evaluation of that behavior, confidentiality can be broken.

4. If you report that you are being abused - physically, emotionally or sexually – or that you have been abused in the past, the law requires that this be reported to the Virginia Department of Social Services.

5. If you are involved in a court case and a request is made for information about your therapy, information will be disclosed with your written consent unless the court *requires* that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with you.

6. If you agree that information can be shared with a specific person or entity, then we will discuss the limits of what will be shared, and how that information will be shared.

Except for situations as described above, your parents/guardians will not be told of specific information you disclose in therapy. This includes activities and behavior that your parents/guardians would not approve of or be upset by, but that do not put you or others at risk for immediate harm. It may be important to let your parents know some information that is protected by confidentiality and you may be encouraged to share that information. Part of the therapist's job is to discuss this with you and to decide together the best way to communicate the information.

Also, parents and guardians may be able to be more helpful if they have general ideas about themes of therapy (such as autonomy, important privileges, achievement, or the status of symptoms) and the therapist may have specific suggestions for parents that do not involve breaking your privacy. Parents are strongly urged to respect the privacy of your treatment and the related records.

Schools and Teachers. Information will not be shared with your school, including that you are even seeing a therapist, unless you and your parents/guardians give permission. If someone from your school wants to talk about your treatment, or if it is decided that talking to someone at your school would be beneficial, then you and your parents will be asked to give their permission for that. If your parents or school want information about the treatment, and you do not want to give permission, then that will be discussed in a session.

Physicians/Doctor's Offices. Your medical doctor may have been involved in referring you for therapy, may have prescribed medication for you, or may be considering prescribing medication. Thus, it may be important to coordinate with your doctor or doctor's office regarding your progress or status, especially when medication is involved or there are other health issues. Again, your permission will be required for such a consultation to occur and it will be important to discuss in therapy what information will be disclosed, especially since some information can be disclosed to a doctor that is not disclosed to your parents. The only time information can be shared with your medical doctor without your permission is if you are engaged in harmful or risky behavior that creates a concern about safety.

Below, you are asked to sign this form, as are your parents/guardians, and you can be given a copy of this if you would like.

Adolescent's Signature: Date:

Parent Signature: Date:

Parent Signature: Date:

Witness Signature: Date: