



## NEW PATIENT INFORMATION: CHILD

Patient Last Name:	Patient First Name:	Patient Middle Name:
DOB:	Biological Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:
Address:	City:	Zip:
Home Phone:	Cell Phone:	Email:

### EMERGENCY CONTACT INFORMATION

First & Last Name:	Relationship:	Phone:
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### INSURANCE INFORMATION

Primary Insurance:	Policy #:	Group #:
Subscriber Name:	Subscriber DOB:	SSN:
Relationship:	Employer:	
Secondary Insurance:	Policy #:	Group #:

### OFFICE USE ONLY:

Policy Effective Date:	<input type="checkbox"/> Calendar Year Plan <input type="checkbox"/> Monthly Plan	
Copay:	Deductible:	Deductible Remaining:
Visit Limit:	Authorization #:	
Appointment Date:	Appointment Time:	Clinician:
DX:		

### I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT.

Patient/Guardian Signature:	Date:
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## **FINANCIAL POLICIES**

Thank you for choosing KaraLee & Associates, P.C. as your mental health care provider. Please understand that payment of services rendered is considered part of your treatment and is expected at each session.

KaraLee & Associates, P.C. providers accept most insurance carriers, but each patient may be responsible for an annual deductible or copayment, depending on their insurance provider. It is the patient's responsibility to keep financial accounts current including copays, deductibles, and service fees.

Please initial below stating you understand our financial policies:

\_\_\_\_\_ I understand that KaraLee & Associates, P.C. has the right to charge me \$60 for missed appointments and cancellations with less than 24 hours notification. Missed appointments or cancellations fees *cannot* be billed to my insurance company.

\_\_\_\_\_ I agree that if for any reason a check is returned on my account, I will be responsible for a \$35 returned check fee in addition to original fee(s) for service(s).

\_\_\_\_\_ I agree to notify KaraLee & Associates, P.C. of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

\_\_\_\_\_ I understand that if my balance remains unpaid for more than 90 days and/or exceeds \$200, KaraLee & Associates, P.C. may refer my account to a collection agency and future services may be withheld.

\_\_\_\_\_ I understand that I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility. Detailed fees for service are listed on the following page.

## FINANCIAL POLICIES CONTINUED

Potential Fees Incurred by Patient	Fee Associated
Records Request (legal, insurance or personal use)	Base Fee: \$23.23 plus:
	Pages 1-20: \$1.16 per page
	Pages 21-50: \$0.58 per page
	Pages 51+: \$0.23 per page
Records Request (continuation of care, records faxed to another medical office only)	Free of Charge
Paperwork/Forms to be completed by clinician or psychiatrist (Short/Long-Term Disability, FMLA, Worker's Compensation)	\$250.00 Charge (psychiatrists to be booked for an hour-long appointment)
Letters to be written by clinician or psychiatrist (Disability, Probation, for School, for Lawyer)	Fee determined by time needed to complete:
	15 minutes: \$62.50
	30 minutes: \$125.00
	45 minutes: \$187.50 60 minutes: \$250.00
Cancellation of Appointment with clinician or psychiatrist (less than 24 hours notice given)	\$60.00
Private Pay Clients (no insurance or insurance not used)	Clinicians - Initial Appointment: \$150.00
	Clinicians - Subsequent Appointments: \$90.00
	Psychiatrist - Initial Appointment: \$200.00
	Psychiatrist - Medication Reviews: \$60.00

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**PATIENT/GUARDIAN SIGNATURE**

**DATE**



## **ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

I, \_\_\_\_\_ agree to arrange a payment plan with my provider to continue services in the event that my insurance coverage lapses or does not cover services rendered. I understand that an Advanced Beneficiary Notice Form (below) must be filled out prior to continuing services.

### **REASON FOR ADVANCED BENEFICIARY NOTICE (Patient/Guardian is responsible for any or all of the following reasons)**

1. Maximum visits allowed per insurance contract have been reached.
2. Patient is insured by straight Medicaid.
3. Deductible, copay, co-insurance not eligible for secondary insurance payment.
4. MD No-Show/ Late Cancel.
5. Therapist No-Show / Late Cancel.
6. Other: \_\_\_\_\_

### **Amount of Payment Responsibility**

**MD Evaluation: \$160.00**

**MD Medication Review: \$60.00**

**No-Show/ Late Cancel: \$60.00**

I agree that I am the responsible party and KaraLee and Associates, P.C. may ask for payment at the time services are rendered. By signing below, I understand that in the event that my insurance does not pay for my mental health services, I agree to pay the amount due for services.

**Patient/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES***

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request:

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

***CONSENT FOR TREATMENT***

I hereby consent to receive treatment for therapeutic/psychological services through KaraLee & Associates, PC:

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

***COMPLIANCE WITH CLINIC REQUIREMENTS***

I hereby acknowledge an understanding of KaraLee and Associates, P.C. requirements. It is required to engage in ongoing therapy in order to maintain appointments with the psychiatrist.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

***UNDERSTANDING OF LEGAL PARTICIPATION***

I hereby acknowledge the legal participation limits of KaraLee and Associates, PC. Therapists and Psychiatrists do not participate in custody proceedings, custody assessments, or court hearings.

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (specify): \_\_\_\_\_



## COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

**\*\*NOT A REQUEST FOR RECORDS\*\***

Patient Name:

DOB:

Authorize  Do Not Authorize

The release of any information to my physician by KaraLee & Associates, P.C.

Physician Name:

Phone #:

Fax #:

Address:

City:

State:

Zip:

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee & Associates, P.C. and my physician. This release expires upon termination of my treatment with KaraLee & Associates, P.C. or upon my written request.

Patient/Guardian Signature:

Date:

### **\*OFFICE USE ONLY\***

Date Admitted/Assessed:

Diagnosis:

#### **TYPE OF TREATMENT & FREQUENCY**

Individual  Family  Group  Referred out

Weekly  Bi-weekly  Monthly  Referral provided to:

Medical Concerns (if any):

Signature of Clinician:

Date:

## Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Biological Sex:  Male  Female

Relationship with the child: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions** (to the parent or guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during **THE PAST TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
		During the past <b>TWO (2) WEEKS</b> , how much (or how often) has your child...					
I.	1.	0	1	2	3	4	
	2.	0	1	2	3	4	
II.	3.	0	1	2	3	4	
III.	4.	0	1	2	3	4	
IV.	5.	0	1	2	3	4	
	6.	0	1	2	3	4	
V. & VI.	7.	0	1	2	3	4	
	8.	0	1	2	3	4	
VII.	9.	0	1	2	3	4	
	10.	0	1	2	3	4	
VIII.	11.	0	1	2	3	4	
	12.	0	1	2	3	4	
	13.	0	1	2	3	4	
IX.	14.	0	1	2	3	4	
	15.	0	1	2	3	4	
X.	16.	0	1	2	3	4	
	17.	0	1	2	3	4	
	18.	0	1	2	3	4	
	19.	0	1	2	3	4	
		In the past <b>TWO (2) WEEKS</b> , has your child ...					
XI.	20.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	21.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	22.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	23.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
XII.	24.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	25.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			

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## PERSONAL HISTORY

Why has the child come into treatment?

What would the child like to accomplish by coming to KaraLee & Associates, P.C.?

Has the child experienced trauma (physical, emotional, sexual)? If so, please explain...

## SCHOOL ADJUSTMENT

School District:

School Name:

Has the child ever been afraid to go to school?

Yes  No

Explain:

Present Grade:

Has the child repeated any grades?  Yes  No

Has he/she ever had problems with the following:  Math  Reading  Language  Speech

Has the child ever had any special education services?  Yes  No

Has the child received complaints from school regarding behavior or achievement?  Yes  No



## SOCIAL INFORMATION

Social time is usually spent:  Alone  Immediate Family  Peers

Please describe:

Does the child isolate him/herself from other people?  Yes  No

Does the child have a job?  Yes  No    Hours a week: \_\_\_\_\_    Position & Type of Work: \_\_\_\_\_

## ADJUSTMENT DIFFICULTIES

Please check any of the following that are typical (or historical) of the child's behavior.

<input type="checkbox"/> Feels Lonely	<input type="checkbox"/> Overactive	<input type="checkbox"/> Defiant	<input type="checkbox"/> Stealing from home	<input type="checkbox"/> Prefers to be alone
<input type="checkbox"/> Shy with children	<input type="checkbox"/> Lacks motivation	<input type="checkbox"/> Daydreams	<input type="checkbox"/> Stealing from peers	<input type="checkbox"/> Preoccupied with sex
<input type="checkbox"/> Shy with adults	<input type="checkbox"/> Sexual acting out	<input type="checkbox"/> Aggressive with... <input type="checkbox"/> Peers <input type="checkbox"/> Siblings <input type="checkbox"/> Adults <input type="checkbox"/> Jealousy	<input type="checkbox"/> Will not admit blame	<input type="checkbox"/> Compulsive behavior
<input type="checkbox"/> Worries	<input type="checkbox"/> Poorly organized		<input type="checkbox"/> Short attention span	<input type="checkbox"/> Ritualistic behavior
<input type="checkbox"/> Moody	<input type="checkbox"/> Tics or twitches		<input type="checkbox"/> Bedwetting - present	<input type="checkbox"/> Talks impulsively
<input type="checkbox"/> Sad	<input type="checkbox"/> Feelings of guilt		<input type="checkbox"/> Bedwetting - past	<input type="checkbox"/> Unusual behavior
<input type="checkbox"/> Cries easily	<input type="checkbox"/> Clumsy		<input type="checkbox"/> Soils self	<input type="checkbox"/> Unusual thinking
<input type="checkbox"/> Expects failure	<input type="checkbox"/> Sets fires	<input type="checkbox"/> Fails to understand consequences	<input type="checkbox"/> Not always truthful	<input type="checkbox"/> Violent behavior
<input type="checkbox"/> Does not share	<input type="checkbox"/> Destructive		<input type="checkbox"/> Exploitation	

## BIRTH & DEVELOPMENT

Normal Pregnancy?  Yes  No    Complications?  Yes  No

Length of Labor: \_\_\_\_\_    Premature?  Yes  No    Weeks/Weight: \_\_\_\_\_

Newborn's Health:

Please check all that apply...

<input type="checkbox"/> Colic	<input type="checkbox"/> Overactive	<input type="checkbox"/> Constipation
<input type="checkbox"/> Eating Issues	<input type="checkbox"/> Underactive	<input type="checkbox"/> Chronic Illness
<input type="checkbox"/> Sleeping Issues	<input type="checkbox"/> Infections	<input type="checkbox"/> High fevers
<input type="checkbox"/> Milk or food allergies	<input type="checkbox"/> Fussy	<input type="checkbox"/> Hospitalization

## EARLY CHILDHOOD

Indicate age started...

Single words: \_\_\_\_\_ months

Sentences: \_\_\_\_\_ months

Walking: \_\_\_\_\_ months

Began Toilet Training: \_\_\_\_\_ months

Ending Toilet Training: \_\_\_\_\_ months

Knew colors: \_\_\_\_\_ months

## CURRENT GENERAL HEALTH STATUS

Name of Physician:

Phone Number:

Are the child's immunizations up to date?  Yes  No

Has the child had an eye exam?  Yes  No      Glasses?  Yes  No

Has the child had a hearing exam?  Yes  No      Hearing deficiency?  Yes  No

Date of last physical exam:

Results:

What is the present health of the child?

Excellent    Very Good    Good    Fair    Poor    Very Poor

## NUTRITIONAL SCREENING

Has the child gained weight in the last 30-60 days?  Yes  No      If yes, how many pounds?

Has the child lost weight in the last 30-60 days?  Yes  No      If yes, how many pounds?

Does the child have any diet or nutritional concerns?  Yes  No

## MEDICATION LOG

List prescribed or over-the-counter medication(s) or herbal supplements your child **currently** takes.

Medication	Dosage	Frequency	Prescriber

**Allergies/Side Effects:**

### FAMILY INFORMATION

Family Member Name	Age	Relationship to Child	Lives with child?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

### RELIGION

Mother:  Catholic  Protestant  Jewish  Muslim  Other:

Father:  Catholic  Protestant  Jewish  Muslim  Other:

Does the family practice one of the parent's religions?  Yes  No

Does the child participate with this religion?  Yes  No

How important are the child's religious beliefs?  Very Important  Somewhat Important  Not Important

### ETHNIC GROUP (OPTIONAL)

Caucasian    African American/Black    Native American    Hispanic    Asian-American    Other

### LEGAL HISTORY

Is the child currently facing any pending charges or convictions?  No    Yes

**Explain:**

Is the child currently on probation?  No    Yes

**Explain:**

Has the child been on probation in the past?  No    Yes

**Explain:**

Has the child ever been arrested or spent time in a corrections facility?  No  Yes

**Explain:**

Is/Has the child been a part of a divorce or custody issue?  No  Yes

**Explain:**

Is the child adopted?  No  Yes

If adopted, have they been told?  No  Yes

### HEALTH QUESTIONNAIRE

Now	Past	Neurological	Now	Past	Disease
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbance			<b>Respiratory</b>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Tics	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
		<b>Digestion</b>	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Constipation			<b>Special Senses</b>
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Hearing disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Visual disorder
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Speech disorder
<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting			<b>Other</b>
<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Under eating	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Pain disorder
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder

**THERAPY GOALS**

Please list what you hope to help your child accomplish through therapy.

1.

2.

3.

4.

**By signing below, I acknowledge that all legal guardians of the child have given consent for treatment.**

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PATIENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**CLINICIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**MEDICAL DIRECTOR SIGNATURE**

\_\_\_\_\_  
**DATE**