South Shore Counseling & Psychological Services, P.C.

3340 Manchester Road, Wantagh, New York 11793
Phone: 516-785-0323 Fax: 516-785-6026

Child/Adolescent Registration Form

EVERYTHING MUST BE FILLED OUT COMPLETELY-PLEASE PRINT CLEARLY.

________________________________ ___________________ __________
Child's Name (Last name, First name) Date of Birth Age

Address: ____

City: _____________________State:_____________________ Zip: _______________

Social Security #:____________________________

Telephone Numbers: (H) ________________ (C) ________________ (Wk) ________________

Name of Father: _____________________________Contact Information: _________________
Name of Mother: ____________________________ Contact Information: _________________
Who is completing this form? ____________________________

Appointment with: ____________________________ Referred by: _______________________

Emergency Contact:
Name: _________________________ Phone: _________________________
Relationship: ____________________

Primary Care Physician's:
Name: _________________________ Phone: _________________________

Child's School Grade: _____________ School Name & Location: __________________________
Phone number: __________________ Teacher's Name: ________________________________

If currently prescribed medication, Psychiatrist's or Prescribing Physician's:
Name: _________________________ Phone: _________________________

If applicable, Case worker, CPS worker, Previous Therapist, Probation officer, or Legal aid's:
Name: _________________________ Phone: _________________________ Title: __________
Name: _________________________ Phone: _________________________ Title: __________
Name: _________________________ Phone: _________________________ Title: __________
Name: _________________________ Phone: _________________________ Title: __________

Reason for Services at this time:
____
____
____
____

Has the child experienced any of the following recently:

____ illness ____ stress ____ accident
____ trauma ____ relocation
____ death of significant person ____ separation from significant person

If so please explain: ____
____
____

A. PREGNANCY HISTORY

Describe the mother's condition during the pregnancy, her health, diet, and state of mind. How much caffeine was used (coffee, Tea, cola)? Alcohol? Tobacco? Marijuana? Other Drugs Prescription Medication? Was a doctor seen regularly?

Please check any of the following that were present during the pregnancy:

___Accident ___Anemia ___Frequent bleeding ___Low blood pressure
___Diabetes ___Infection ___Transfusion given ___High blood Pressure
___Anxiety ___Surgery ___Rh incompatibility ___Family problems
___Depression ___HIV ___Stomach problems ___Other: __________________

How many births before this child? ____ How many miscarriages? ____ Age of mother at child's birth? ____

Before the pregnancy, what medication
(prescribed or over the counter) did the mother take? List them ____
During the pregnancy, what medication
(Prescribed or over the counter) did the mother take? List them ____
Post-pregnancy, what medication
(prescribed or over the counter) did the mother take? List them ____

B. BIRTH HISTORY

Is the child ___ a foster child or ___an adopted child.
The pregnancy lasted ___weeks: the labor lasted ___hours
The child was born ___on the time / ___weeks early / ___ weeks late.
Labor was ___ easy /___ somewhat difficult /___hard /___very difficult. Forceps were used? ___ yes ___no
The delivery was ___Cesarean I ___Natural I ___local anesthesia / ___ general anesthesia
The delivery was: ___ head first I ___other: (specify) ____

Was anything unusual at birth? Please check all that apply and add more details below:

___Cord around neck ___Baby didn't cry ___Baby needed transfusion ___Blue baby
___Prolapsed cord ___Had trouble breathing ___Baby was jaundice ___PKU
___Low placenta ___Needed oxygen ___Had Difficulty feeding ___Needed incubator
___Separated placenta ___Baby was unresponsive ___Had difficulty sucking ___Fetal Alcohol Syndrome
___Birth Defect Explain: ___________________
Give details or note anything else that was unusual:

C. INFANCY and EARLY CHILDHOOD

Child's weight at birth: ___Ibs. ___ oz.
Weight when leaving Hospital: ___Ibs ___ oz.
Age when first crawled: ___
Age when first word spoken: ___
Age when first sentence spoken: ___
Age when toilet trained: ___

How long was baby in hospital? ___
Age when able to sit up by self: ___
Age when took first steps alone: ___
Age when first phrase was spoken: ___
Child was ___ left/___ right handed at age ___
Toilet training was ___very easy /___easy /___hard /___very hard.

Child was fed by ___breast /___ formula and was weaned from breast or bottle at age ____________

Please check any of the following difficulties your child may have or has had. Giving details below:

___Walking
___Running
___Falling
___Playing Sports
___Speech/ Language delay
___Weak muscles
___Muscle tension
___Stiffness
___Says very little
___Hard to understand verbally
___Shy and inhibited
___Difficulty writing
___Difficulty drawing
___Irritability
___Difficulty feeding and digesting
___Fearfulness
___Very clinging

Give details or note anything else that was unusual:

D. CHILDHOOD ILLNESS

Please check all diseases or conditions that have occurred:

___allergies
___anemia
___asthma
___bleeding disorder
___blood disorder
___brain disorder
___broken bones
___cancer
___cerebral palsy
___chicken pox
___chronic bronchitis
___diabetes
___encephalitis
___enzyme deficiency
___frequent colds
___frequent ear infections
___frequent stomach upset
___genetic disorder
Explain ____________
___heart disorder
___jaundice
___kidney disorder
___leukemia
___liver disorder
___lung disorder
___Lyme disease
___measles
___metabolic disorder
___meningitis
___mumps
___pneumonia
___rheumatic fever
___scarlet fever
___seizures
___tuberculosis
___venereal disease
___whooping cough

Child's doctor or clinic: ___________________ Phone number? ___________________

If child has any allergies, please list: ____

Psychological services received by child in the past or at present:

Age at time	Length of Treatment	Reason for Treatment	Past	Present

Psychiatric medications that child has taken or is taking now:

Medication & Dosage	When taken	Reason for medication	Past	Present

Hospitalizations (or other Medical Services) of child for surgery, illness, or accident:

Age at time	Length of stay	Reason for hospitalization	Location

Any vision difficulty? ___No/ ___Yes Have eyes been examined? ___No/ ___Yes, when? ____________
Any hearing difficulty? ___No/ ___Yes Have ears been examined? ___No/ ___Yes, when? ____________

Children are often affected by the relationship problems or emotional problems of other people in the home. Please indicate whether or not there are such difficulties at home. ___Yes ___No

If so, describe and state your opinion whether this affects your child's behavior or learning problems.

Describe whether the child or any other Family members have been or are being seen for psychotherapy or counseling:

E. HOME LIFE

What is the primary language spoken in the home? ____________________ Others: _______________________

Have there been any major family stresses or changes in the past year (e.g. moving with change of school, divorce, significant illness, death of a family member, etc.)?

Do the parents or guardians of this child agree on ways to help the child? ___Yes ___No Please explain:

How is your child disciplined and by whom?

Parents or guardians see a lot more of their child than others do. Often they see good points that only come out at home. What do you think are some of the best things about your child?

F. FAMILY HISTORY

Is there any history of problems among the extended family of the child (mother, father, brother, sister, aunt, uncle, cousin, or grandparent)? Problems such as vision, hearing, speech, or movement: seizures, mental retardation or mental illness: learning disability or other disability. If so, please list them here.

Relationship of Person to child:	Nature of problem:
______________________	____
______________________	____
______________________	____
______________________	____

G. OTHER HISTORY

Please state which grades were repeated, if any, and describe why:

List any special services your child has received either at school or through an outside agency.

Service	Grade at time	Name of provider
Educational Testing	______________	_____________________________
Reading or Math Help in school	______________	_____________________________
Outside tutoring	______________	_____________________________
Special Class Placement	______________	_____________________________
Occupational Therapy	______________	_____________________________
Psychology Testing	______________	_____________________________
Psychiatric Consultation	______________	_____________________________
Psychological Therapy	______________	_____________________________
Speech & Hearing evaluations	______________	_____________________________
Speech Therapy	______________	_____________________________

H. BEHAVIOR

	Rarely	Now and Then	Sometimes	Often
Plays well with brothers/sisters				
Plays by self				
Plays with friends				
Sleeps poorly				
Has nightmares				
Bites				
Sucks thumb				
Runs away				
Has a bad temper				
Cooperative at home				
Cooperative at school				
Makes friends easily				
Feels afraid				
Is obedient at home				
Is obedient at school				
Pays attention at home				
Pays attention at school				
Does homework by self				
Gets into fights				
Daydreams				
Cries easily				
Wets Bed				
Tells lies				
Becomes to excited				
Takes others' things				
Watches TV				
Helps around the house				
Seems quiet and withdrawn				
Talks about self to family				

Has child had any legal problems? No ____ Yes ____ If yes, briefly describe:

____

I. REVIEW

Please review the information you have given above. What has been left out? What can add to give a more accurate and more complete picture of your child?

If your best hopes and wishes for your child were to be achieved in the future, how would he or she be different from now?

I certify this information is true and correct to the best of my knowledge. I understand that all psychological services are performed under the supervision of, Dr. William James, Director of South Shore Counseling & Psychological Services. I understand that all information that I communicate will be held in strict confidence. I also understand that New York State also mandates certain limits to confidentiality.

Parent or Guardian's Signature: ____ Date: _______________

Insurance Information

Primary Insurance Co:_________________________Address:______________________________

City:___________________________State:_________Zip:________Phone:___________________

Insurance ID #:____________________________Policy Holder:______________________________
_
Policy Holder's Date of Birth:_______________Policy Holder's Address_____________________

__________________________________State:_______Zip:_______Phone:__________________

Secondary Insurance Co.______________________Address_______________________________

City:__________________________State:_________Zip:________Phone:___________________

Insurance ID#_____________________________Policy Holder: ____________________________

Policy Holder's Date of Birth:_______________Policy Holder's Address:____________________

__________________________________State:_______Zip:_______Phone:_________________

**Please make sure you take care of paying your co-pay at the time of your appointment before leaving the office, if you have one. If we have to bill you there will be an extra $15.00 Administration Fee that you will be responsible for paying too.*

**If you must cancel an appointment please notify your therapist or the office 24 hours in advance. There is a $65.00 fee for a missed/no show appointment or a cancellation with less than a 24 hour notice.*

Our schedules are booked in advance. If for any reason when you get home and check your schedule there is a conflict, please call right away so we can accommodate you. We will try our best to notify you of any schedule changes in advance too. ~Thank you for your cooperation.

Who is responsible for this bill? ____

I certify this information is true and correct to the best of my knowledge. I understand the above statements and I will notify SSCPS of any changes in my health insurance status. If I do not notify you of any changes and my insurance does not cover any services rendered, I will be ultimately responsible.

Signature:______________________________________ Date:_______________

South Shore Counseling & Psychological Services

Patient Privacy Policy

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment and/or health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. The refusal must be made in writing. Under the HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have received our privacy notice.

Print Name_________________________Signature______________________Date__________

SOUTH SHORE COUNSELING & PSYCHOLOGICAL SERVICES, PC
Patient Bill of Rights and Responsibilities

Patient Rights

I have a right to efficient and effective care individualized to my needs. *My treatment provider will work with me to develop a treatment plan best suited to me. We will use this plan to help us deal with my problems as quickly and effectively as possible.*

I have a right to be treated with dignity and respect. *I will be treated with respect at all times. I will report any misconduct by my treatment provider including social invitations, suggestive remarks, or unwanted touching to the Administrative Director of SSCPS and/or the appropriate state agency.*

I may call the Administrative Director of SSCPS at any time with questions, comments or complaints.

My treatment provider will make every effort to meet with me at our scheduled appointment time. *If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.*

I have a right to privacy and confidentiality. *All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my mental health provider to report suspected abuse or neglect, domestic violence and those who pose a danger to themselves or others.*

Patient Responsibilities

Scheduled appointments are commitments*. I will make every effort to be on time for my appointment(s). If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my treatment provider at least 24 hours in advance, I understand I will be charged a missed appointment fee.*

I am responsible to pay for services received. *I am aware my insurance plan typically requires me to pay a co-payment (a dollar amount) or co-insurance (a percentage of my treatment provider's fee) at the time services are provided. My insurance plan may also have a deductible (an initial dollar amount) that is my responsibility. Additionally, certain services may be limited and not covered at all by my insurance plan. I understand I am financially responsible for co-payments, co-insurance, deductibles and all services not covered by my insurance plan. My treatment provider, my managed care and my insurance plan's representative will help me determine what services my insurance plan covers.*

My health is my responsibility. *I will contact my treatment provider for any serious situation that arises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my treatment provider of changes in my condition.*

I have read this list of rights and responsibilities or had them read to me. I understand and agree to them.

Print Name______________________________Signature_______________________Date ________________