



NEW PATIENT INFORMATION: CHILD

Patient Last Name: _____ Patient First Name: _____ Patient Middle Name: _____

DOB: _____ Biological Sex: M F SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

First & Last Name: _____ Relationship: _____ Phone: _____

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
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Copay: _____ Deductible: _____ Deductible Remaining: _____

Visit Limit:	Authorization #:
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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

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: _____
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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: _____
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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 TWO (2) WEEKS , how much (or how often) has your child...						
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past TWO (2) WEEKS , has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
XII.	24.	In the past TWO (2) WEEKS , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	<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			Respiratory
<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
		Digestion	<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			Special Senses
<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			Other
<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