NEW PATIENT INFORMATION CHILD/ADOLESCENT

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: ☐ Calendar Year Plan ☐ Monthly Plan

Copay: Deductible: Deductible Remaining:

Authorization #:

Visit Limit:

Appointment Date: Appointment Time: Clinician:

DX:

I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT

Patient/Guardian Signature: Date:

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.

By initialing each paragraph below, you are stating that you understand our financial policies.

_____ (initial here) 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.

_____ (initial here) 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).

_____ (initial here) 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.

_____ (initial here) 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.

_____ (initial here) 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.

_____ (initial here) I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request.

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 hour 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
(print name here)
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 BENIFICIARY 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: $200.00

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 (please explain):

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 ☐ Testing Only ☐ Referred out	☐ Weekly ☐ Bi-weekly ☐ Monthly
☐ Referral provided to: Medical Concerns (if any):	

Signature of Clinician: Date:

KaraLee & Associates
centre for self and family

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.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	☐	☐	☐	☐	☐	
	2.	Said he/she was worried about his/her health or about getting sick?	☐	☐	☐	☐	☐	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	☐	☐	☐	☐	☐	
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?	☐	☐	☐	☐	☐	
IV.	5.	Had less fun doing things than he/she used to?	☐	☐	☐	☐	☐	
	6.	Seemed sad or depressed for several hours?	☐	☐	☐	☐	☐	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	☐	☐	☐	☐	☐	
	8.	Seemed angry or lost his/her temper?	☐	☐	☐	☐	☐	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	☐	☐	☐	☐	☐	
	10.	Slept less than usual for him/her, but still had lots of energy?	☐	☐	☐	☐	☐	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	☐	☐	☐	☐	☐	
	12.	Not been able to stop worrying?	☐	☐	☐	☐	☐	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	☐	☐	☐	☐	☐	
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?	☐	☐	☐	☐	☐	
	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?	☐	☐	☐	☐	☐	
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?	☐	☐	☐	☐	☐	
	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?	☐	☐	☐	☐	☐	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	☐	☐	☐	☐	☐	
	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?	☐	☐	☐	☐	☐	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ 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)?	☐ Yes	☐ No	☐ 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)?	☐ Yes	☐ No	☐ 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?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

PERSONAL HISTORY

Why has child/adolescent come into treatment?

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

SUICIDE & SELF-HARM

(circle or check yes or no)

Have they ever thought about suicide or harming themselves? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they have a history of suicide attempts or self-harm? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they currently feel suicidal? (If yes, please explain in the space provided below…)	**yes** ☐	**no** ☐

Explain:

HOMICIDAL ISSUES

(circle or check yes or no)

Have they ever thought about killing or harming others? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they have a history of committing murder or harming others? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they currently feel homicidal? (If yes, please explain in the space provided below…)	**yes** ☐	**no** ☐

Explain:

TRAUMA HISTORY

Have you experienced any of the following…

(If answered yes to any, please explain in the space provided on the next page…) (circle or check yes or no)

emotional abuse	**yes** ☐	**no** ☐
physical abuse	**yes** ☐	**no** ☐
sexual abuse	**yes** ☐	**no** ☐
emotional neglect	**yes** ☐	**no** ☐
physical neglect	**yes** ☐	**no** ☐
physical assault	**yes** ☐	**no** ☐
sexual assault	**yes** ☐	**no** ☐
crime-related events	**yes** ☐	**no** ☐
general disaster	**yes** ☐	**no** ☐

Explain (Trauma History):

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

Please explain:

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.

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

☐ Colic	☐ Overactive	☐ Constipation
☐ Eating Issues	☐ Underactive	☐ Chronic Illness
☐ Sleeping Issues	☐ Infections	☐ High fevers
☐ Milk or food allergies	☐ Fussy	☐ 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
Did the child ever have an eye exam? ☐ Yes ☐ No Glasses? ☐ Yes ☐ No
Did the child ever have 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?
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ 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
Explain:

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

If any are checked, please explain:

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**