CHILD & TEEN PATIENT INFORMATION
PARENT FILLS THIS OUT

Child / Teen Name: _____**MI**_____ **Last Name**: _____

Birth Date: _____/_____/_____ Age: _____ Grade Level: _____ School _____

Parent Email:_____

RESPONSIBLE PARTY
Mother _____ Father _____
Address: _____
City: _____St._____Zip_____
Home Phone: _____ Work Phone: _____ Cell _____

PRIMARY INSURANCE CO: _____ Insurance ID # _____
Group # _____ Policy Holder Name_____ Birth Date: _____/_____/_____
Employer:_____
Marital Status: Single ○ Married ◉ Divorced ○ Widow ○

SECONDARY INSURANCE CO:_____Employer:_____
Policy Holder Name: _____ Group# _____ Insurance ID # _____
Work Phone _____ Home Phone _____Birth Date _____/_____/_____

Problem or concern for your child / teen which you are seeking treatment?

What has been done to try to solve this concern?

What changes are you seeking?

Describe your parenting strengths: Describe your parenting weaknesses:

Previous therapists? Yes When & was it helpful? _____

Are there current suicidal thoughts? No Attempted suicide? No

Difficulty with your child's anger? No Been violent? No Injured someone? No

Have your child ever had problems with alcohol or drugs? No

Does your child smoke? No How much/often ____ _____

How much coffee, colas, or teas do you drink per day? _____

Family history of mental health or substance abuse problems?_____

Check any that have happened: Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐

Have you had a head injury with loss of consciousness or caused you to see a doctor? Yes

Have you had any of the following:

Learning disabilities ☐ Hyperactivity ☐ Disciplinary problems ☐

Menstrual problems ☐ Possible PMS ☐ Premenopausal/Menopausal ☐

Any type of sleep problems: Falling asleep ☐ ☐ Early awakening ☐ Difficulty awakening ☐

Any appetite changes Yes Weight changes Yes Current weight: _____ lbs. Height: _____

Describe your worst nutritional habits _____

Legal Problems? Arrests? _____

Exercise? Frequency of physical activity? _____

Hobbies / Interests? _____

Describe your religious or spiritual beliefs _____

Check any of the following concerns - Make any additional comments

Shyness ☐	Panic ☐	Attention Deficit ☐	Phobias ☐
Health ☐	Controlling ☐	Over-Weight ☐	Stress ☐
Inferiority ☐	Depression ☐	Bullying ☐	Obsessions ☐
Self-Injury ☐	Concentration ☐	Guilt ☐	Insecurity ☐
Memory Problems ☐	Self-Esteem ☐	Eating Disorder ☐	Attitude ☐
Ambition ☐	Confusion ☐	Spending ☐	
Work ☐	Perfectionism ☐	Drug Use ☐	
Anger ☐	Relationship ☐	Gambling ☐	
Jealousy ☐	Mood Swings ☐	Self Critical ☐	
Nervousness ☐	Career ☐	Compulsions ☐	
Making Decisions ☐	Physical Pain ☐	Worry ☐	

Comments:

Describe your childs health at present

List any medical problems your child may have

List any operations

List any allergies you have, including allergies to medications

List any recently discontinued medications, psychiatric medications

List medications you are taking	Dosage	Number of times per day	Prescribed since when

If there is a need to call, may we leave a message on voice mail or with a family member? Yes
May we inform your physician of evaluation results? Yes
May we inform your psychiatrist of evaluation results? Yes

Primary physician: _____ Address:_____
Ph.:_____ Fax:_____ (Complete address is needed)

(Please fill out next page)

(Please fill out next page)

AUTHORIZATION FOR TREATMENT

I, _____ (Parent/Representative), authorize and consent to the treatment of patient named above. I understand that payment is required at time of service, and take full responsibility for all fees resulting from treatment. Medical/Mental Health treatment rendered cannot guarantee outcome.

Although I may have insurance or a financial agreement with a third party, I am aware that I am ultimately responsible for fees incurred as a result of services rendered. I also accept financial responsibility as outlined below, even though that may be discrepant from the policies of my insurance carrier.

Insurance Assignment:
I authorize the release of medical information necessary to process my claims. I authorize payment of medical benefits to DAVIS SOUND MIND, MARK DAVIS, LCSW, NICOLE DAVIS, LCSW for services rendered. I acknowledge and understand that I am responsible for all charges for all services rendered to me or any member of my family. Although I have requested my insurance company to be billed directly by this office, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable time period. If any portion of my bill is not paid by my insurance for any reason, including failure to obtain authorization, within 90 days of filing, I am responsible for the full amount.

The practice of DAVIS SOUND MIND does implement periodic rate increases, usually at times of six to twelve months.

Appointment Cancellation Policy:
Please call twenty-four hours before, or by 3pm the day prior to cancel your appointment. Workplace demands that you cancel your medical appointments are not acceptable.
Late Cancellation: **$110.00** Less than 24 hours cancellation. This will be processed on you card on file.
Missed Appointments: $110.00 will be charged for a missed appointment. This will be processed on you card on file.
Returned Checks: $35.00 fee for returned checks.
Forms: There is a $50.00 charge for all forms from external agencies. FMLA, DUI, etc We do require you to submit all forms with four days advance to any deadline**.**
Document Fax/Copy $1.00 per page. **Forms Policy:** There is a $50.00 charge for all forms from external agencies. FMLA, DUI, etc

_____ _____
PATIENT SIGNATURE DATE

_____ _____
Legally Authorized Representative Signature DATE

Notice of HIPPA
This office is permitted to disclose
1. Personal Health Information (PHI) to federal and state agencies that regulate or investigate the health care industry.
2. PHI to accreditation organizations, insurance companies, and care management companies.
3. Law enforcement officials, subject to applicable state and federal laws for purposes of complying with court subpoenas or other legal process.