CHILD & TEEN PATIENT INFORMATION
PARENT FILLS THIS OUT

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

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

Parent Email:_____ Ethnic/Cultural Identity:_____

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? _____ When? _____ Was it helpful? _____

Are there current suicidal thoughts? ____YES ____ NO Attempted suicide? ____YES ____ NO

Difficulty with your child's anger? ___ YES ___ NO, been violent? ___ YES ___ NO or injured someone?___ YES ___ NO

Have your child ever had problems with alcohol or drugs? ___YES ___NO

Does your child smoke? ___ How much_____

How much coffee, colas, or teas does your child drink per day? _____

Family history of mental health or substance abuse problems?_____

Circle any that have happened: emotional abuse physical abuse sexual abuse

Have your child had a head injury with loss of consciousness? _____ YES _____ NO

Does your child have _____learning disabilities, _____hyperactivity or _____disciplinary problems?

Menstrual problems? ____ Possible PMS?____

Any type of sleep problems?_____

Any appetite changes? _____or weight changes?_____

Legal Problems? Arrests? _____

Exercise? Frequency of physical activity ? _____

Hobbies / Interests? _____

Describe your religious or spiritual beliefs_____

Circle any of the following concerns - Make any additional comments

Attention Deficit	Guilt
Over-Weight	Eating Disorder
Bullying	Spending
Alcohol	Drug use
Low energy	Gambling
Self Critical	Critical
Sexual Issues	Marriage
Anxiety	Relaxation
Compulsions	Phobias
Fears	Worry
Stress	Obsessions
Insecurity	Attitude
Shyness	Health
Inferiority	Self Injury

Memory Problems	Academic Achievement
Work	Anger
Jealousy	Panic
Controlling	Depression
Concentration	Self Esteem
Confusion	Perfectionism
Relationship	Mood Swings
Career	Nervousness
Making Decisions	Physical pain

Describe your child's health at present_____

List any medical problems your child has: _____

_____

List any operations: _____ _____

_____

List any allergies, including allergies to medications: _____

_____

List any recently discontinued medications, psychiatric medications?_____
_____

List medications	**Dosage**	**Number of times per day**	**Prescribed since when?**

If there is a need to call, may we leave a message on voice mail? _____ YES ____ NO
May we inform your pediatrician of evaluation results? _____ YES _____ NO or psychiatrist? _____ YES _____ NO

Primary physician: _____ Address:_____

Ph.:_____ (Complete address is needed) _____
_____ ____

_____ _____

SIGNATURE **DATE**

(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: **$70.00** Less than 24 hours cancellation. This will be processed on you card on file.
Missed Appointments: $70.00 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.