Child/Adolescent New Patient Packet

MIDWEST RESEARCH GROUP
ST. CHARLES PSYCHIATRIC ASSOCIATES
4801 WELDON SPRING PARKWAY • SUITE 300
ST. CHARLES, MO 63304

Patient Information:

Name: ____________ ____________ ____________
(LAST) (FIRST) (M.I.)

Address: ____________ City, State, Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

SSN: ____________ DOB: ____________ Marital Status: ____________ Sex: ____________

Employer: ____________ PCP: ____________ Therapist: ____________

Referred by ____________ Drug Allergies: ____________

Emergency Contact: ____________ Telephone Number: ____________

Responsible Party:

Name: ____________ ____________ ____________
(LAST) (FIRST) (M.I.)

Address: ____________ City, State, Zip: ____________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Relationship to Patient: ____________ Employer: ____________

Primary Insurance:

Policy Holder ____________

Ins. Company ____________

Ins. ID # ____________

Policy/Group # ____________

Effective Date ____________

Birth Date of Policy Holder ____________

Social Security # of Policy Holder ____________

Employer ____________

Secondary Insurance:

Policy Holder ____________

Ins. Company ____________

Ins.ID # ____________

Policy/Group # ____________

Effective Date ____________

Birth Date of Policy Holder ____________

Social Security # of Policy Holder ____________

Employer ____________

PLEASE READ:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PAYMENT IS ALSO EXPECTED FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER. THIS ELECTRONIC SIGNATURE IS CONSIDERED AS AN ORIGINAL.

I AUTHORIZE ST. CHARLES PSYCHIATRIC ASSOCIATES TO EXCHANGE AND OBTAIN INFORMATION WITH IT'S AFFILIATED THERAPISTS AND TO CONTACT MY PRIMARY CARE PHYSICIAN, AS NOTED ABOVE IN REGARDS TO ANY AND ALL TREATMENT. THIS ELECTRONIC SIGNATURE IS CONSIDERED AS AN ORIGINAL. ****FAILURE TO CANCEL APPOINTMENT WITHOUT 24 HOUR NOTICE WILL RESULT IN A FEE OF $45.00 FOR M.D. AND/OR $90.00 FOR THERAPIST**.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I HEREBY AUTHORIZE ST. CHARLES PSYCHIATRIC ASSOCIATES AND IT'S AFFILIATED THERAPISTS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) AND THERAPIST(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. THIS ELECTRONIC SIGNATURE IS CONSIDERED AS AN ORIGINAL.

____________ Signature of Patient or Legal Guardian

____________ Signature of Insurance Policy Holder

____________ Date

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Statement of Confidentiality

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in State or Federal regulations

I have read and understand the above statement. This electronic signature is considered as an original.

PATIENT SIGNATURE OR PARENT SIGNATURE (if patient is under 18)

Consent for Treatment

I, ______, hereby give my consent for necessary medical evaluations and treatments. This electronic signature is considered as an original.

I hereby authorize this office to release medical records pertaining to my condition to all appropriate parties for the purpose of coordinating my medical care and/or obtaining insurance payment.

PATIENT SIGNATURE

PARENT SIGNATURE (if patient is under 18)

DATE

RELATIONSHIP TO PATIENT

MIDWEST RESEARCH GROUP
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement. This electronic signature is considered as an original.

I, __________, have received a copy of this office's Notice of Privacy Practices.

Print Name: __________

Signature: Date: __________

For 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 situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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CHILD/ADOLESCENT CONFIDENTIAL QUESTIONNAIRE

DATE:
NAME: AGE: GRADE:
SIBLINGS:

1. Please describe your child/adolescent's problem

2. When did the problem start?

3. Were your child's pregnancy & delivery normal?

4. Were there any delays in development (walking, talking, etc.)?

5. Has your child previously seen a psychiatrist or counselor? Was a diagnosis given?

6. Has your child ever taken psychiatric medication? Please list:

7. Any psychiatric hospitalizations? List dates:

8. Has your child ever talked about or attempted suicide?

9. Any problems at school? Please describe:

10. Please list average grades during this past school year.

11. Any alcohol or drug use? Please describe:

12. Has your child ever had legal problems? Please describe:

13. Any history of emotional, physical or sexual abuse? Please describe:

14. Any family history of psychiatric problems? Please describe:

15. Please check any issues that apply to your child:

- Low mood
- Sleep problems (Increased / decreased)
- Appetite problems (increased / decreased)
- Crying
- Low energy level
- Motivation problems
- Social adjustment problems
- Anxiety or unusual fears
- Attention problems
- Impulsivity
- Hyperactivity
- Temper tantrums
- Oppositional behavior
- Truency / School refusal
- Fighting
- Eating Disorder (binging, purging, other)
- Compulsive thoughts or obsessive behaviors
- Head injury / concussion
- Loss of consciousness
- Meningitus
- Tics (unusual face or body movements

16. Family physician?

17. Drug Allergies?

18. Current medications?

19. Surgeries?

20. Hospitalizations?

21. Medical problems?

22. What do you want to improve for your child as a result of treatment?

PHQ-9 Modified for Adolescents (PHQ-A)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite, weight loss, or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes?

Yes **No**

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

Yes **No**

Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?

Yes **No**

ADHD Self-Report Scale Symptom Checklist

Check the rating which best describes this person's behavior in the past TWO weeks **Who is completing this form?** **Parent/Guardian** **Child**	Never	Rarely	Sometimes	Often	Very Often
1. Fails to give close attention to details or makes careless mistakes in work	☐	☐	☐	☐	☐
2. Fidgets with hands or feet or squirms in seat	☐	☐	☐	☐	☐
3. Difficulty sustaining attention in tasks or fun activities	☐	☐	☐	☐	☐
4. Leaves seat in classroom or in other situations in which seating is expected	☐	☐	☐	☐	☐
5. Does not listen when spoken to directly	☐	☐	☐	☐	☐
6. Feels restless	☐	☐	☐	☐	☐
7. Does not follow through on instructions and fails to finish work	☐	☐	☐	☐	☐
8. Has difficulty engaging in leisure activities or doing fun things quietly	☐	☐	☐	☐	☐
9. Has difficulty organizing tasks and activities	☐	☐	☐	☐	☐
10. Feels "on the go" or "driven by a motor"	☐	☐	☐	☐	☐
11. Avoids, dislikes, or is reluctant to engage in work that requires sustained mental effort	☐	☐	☐	☐	☐
12. Talks excessively	☐	☐	☐	☐	☐
13. Loses things necessary for tasks or activities	☐	☐	☐	☐	☐
14. Blurts out answers before questions have been completed	☐	☐	☐	☐	☐
15. Easily distracted	☐	☐	☐	☐	☐
16. Has difficulty awaiting turns	☐	☐	☐	☐	☐
17. Forgetful in daily activities	☐	☐	☐	☐	☐
18. Interrupts or intrudes on others	☐	☐	☐	☐	☐

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At St. Charles Psychiatric Associates (hereinafter referred to as "**the Practice**"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with the information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

- X *Sharing information within **the Practice***. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- X *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- X *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us - whether it's at our office, over the phone, or through the Internet.

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