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

Today's Date:

Patient:
DOB:

Services Rendered:

PLEASE READ:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT.NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS.HOWEVER, THE PATIENTIS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PAYMENTIS ALSO EXPECTED FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

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 REGARD TO ANY AND ALL TREATMENT.

**FAILURE TO CANCEL APPOINTMENT WITHOUT 24 HOUR NOTICE WILL RESULT IN A FEE OF $45.00 FOR M.D./N.P. AND/OR $90.00 FOR THERAPIST.

Stimulate Fee Policy

I understand that all patients that are on a stimulate medication, or may be prescribe a stimulate medication, agrees to pay our stimulate fee of $50.00 every 6 months.

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 PAYMENTSFOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

St. Charles Psychiatric Associates reserves the right to deny appointments and/or medication refills for accounts with outstanding balances if payments cannot be made in a timely manner. Copays, coinsurance portions, and self-pay rates are due at the time of service. At no point in time do we want this policy to be considered abandonment of care, so we ask patients to maintain timely payments or work with office staff to initiate payment plans to ensure continuation of care.

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.

Consent for Treatment:

I hereby give my consent for necessary medical evaluations and treatments.

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.

I hereby give my consent for telehealth visits as scheduled with the MD/NP and/or therapist.

Today's Date:

Patient:
DOB:

Notice of Privacy Practice

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

While 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 your 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

- *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.
- *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.
- *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.

St. Charles Psychiatric Associates

4801 Weldon Spring Parkway, Suite 300

St. Charles, MO 63304

(636) 949-5760

Acknowledgement of Receipt of Notice of Privacy Practices:

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

____

Phone:
Fax:

Child / Adolescent Confidential Questionnaire

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. Please check any problems that apply to your child:

Phone:
Fax:

Child / Adolescent Confidential Question

- ❐ Low mood
- ❐ Sleep problems (increased / decreased)
- ❐ Appetite problems (increased / decreased)
- ❐ Crying
- ❐ Energy level
- ❐ Motivation problems
- ❐ Social adjustment problems
- ❐ Anxiety or unusual fears
- ❐ Eating disorders (binging / purging, laxative abuse)
- ❐ Temper tantrums
- ❐ Oppositional behavior
- ❐ Truancy / school refusal
- ❐ Fighting
- ❐ Hyperactivity
- ❐ Compulsive thoughts, obsessive behaviors
- ❐ Attention problems
- ❐ Impulsivity

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

10. Any problems at school? Please Describe:

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

12. Any drug or alcohol use? Please Describe:

Phone:
Fax:

Child / Adolescent Confidential Question -

13. Has your child ever had legal problems? Please Describe:

14. Any history of emotional, physical, or sexual abuse?

15. Is there any family history of psychiatric problems? Please List:

Medical History

Family Physician:

Current Medications:

Surgeries:

Hospitalizations:

Medical Problems:

Drug Allergies:

Check all that apply:

- ❐ Head Injury
- ❐ Loss of Consciousness
- ❐ Meningitis
- ❐ Tics (unusual face or body movements)

16. Any medication allergies Please List:

Phone:
Fax:

Child / Adolescent Recent Behavior - ..

Recent Behavior Survey

Please circle the number next to each item that best describes your child's behavior

DURING THE PAST 6 MONTHS.

0=Never or Rarely 1=Sometimes 2=Often 3=Very Often

1. Fail to give close attention to details or make careless mistakes in my work

2. Fidget with hands or feet or squirm in seat

3. Difficulty sustaining my attention in tasks or fun activities

4. Leave my seat in classroom or in other situations in which seating is expected

5. Don't listen when spoken to directly

6. Feel restless

7. Don't follow through on instructions and fail to finish work

8. Have difficulty engaging in leisure activities or doing fun things quietly

9. Having difficulty organizing tasks and activities

10. Feel "on the go" or "driven by a motor"

Phone:
Fax:

Child / Adolescent Recent Behavior -

11. Avoid, dislike, or am reluctant to engage in work that requires sustained mental effort

12. Talk excessively

13. Lose things necessary for tasks or activities

14. Blurt out answers before questions have been completed

15. Easily distracted

16. Have difficulty awaiting turn

17. Forgetful in daily activities

18. Interrupt or intrude on others

Phone:
Fax:

CHILD ADHD Rating Scale -

ADHD Rating Scale-IV: Home Version

Completed By

Circle the number that best describes your child's home behavior over the past 6 months.

Never or Rarely	Sometimes	Often	Very Often
0	1	2	3

1. Fails to give close attention to details or makes careless mistakes in schoolwork.

2. Fidgets with hands or feet or squirms in seat.

3. Has difficulty sustaining attention in tasks or play activities.

4. Leaves seat in classroom or in other situations in which remaining seated is expected.

5. Does not seem to listen when spoken to directly.

6. Runs about or climbs excessively in situations in which it is inappropriate.

7. Does not follow through on instructions and fails to finish work.

8. Has difficulty playing or engaging in leisure activities quietly

Phone:
Fax:

CHILD ADHD Rating Scale -

9. Has difficulty organizing tasks and activities

10. Is "on the go" or acts as if "driven by a motor."

11. Avoids tasks (eg, schoolwork, homework) that require sustained mental effort.

12. Talks excessively.

13. Loses things necessary for tasks or activities

14. Blurts out answers before questions have been completed

15. Is easily distracted.

16. Has difficulty awaiting turn.

17. Is forgetful in daily activities.

18. Interrupts or intrudes on others.

Phone:
Fax:

Child Behavior Screening

Over the last 2 weeks, how often have you been bothered by the following problems?

Not At All	Several Days	More Than Half The Days	Nearly Every Day
0	1	2	3

1. Fails to give close attention to details or makes careless mistakes in schoolwork.

2. Fidgets with hands or feet or squirms in seat.

3. Has difficulty sustaining attention in tasks or play activities.

4. Leaves seat in classroom or in other situations in which remaining seated is expected.

5. Does not seem to listen when spoken to directly.

6. Runs about or climbs excessively in situations in which it is inappropriate.

7. Does not follow through on instructions and fails to finish work.

Phone:
Fax:

Posttraumatic Stress, Child - 5/11/2023

Who filled out this form?

People sometimes have problems after extremely stressful events or experiences. How much have you been bothered by each of the following problems that occurred or became worse after an extremely stressful event/experience?

Please list the traumatic event you experienced

Date of the traumatic event.

Over the last 7 days, how often have you experienced any of the following? Be sure to answer ALL the questions.

1. Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?

2. Feeling very emotionally upset when something reminded you of a stressful experience?

3. Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?

4. Thinking that a stressful event happened because you or someone else (who didn't directly harm you) did something wrong or didn't do everything possible to prevent it, or because of something about you?

Phone:
Fax:

Posttraumatic Stress, Child - 5/11/2023

5. Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?

6. Losing interest in activities you used to enjoy before having a stressful experience?

7. Being "super alert," on guard, or constantly on the lookout for danger?

8. Feeling jumpy or easily startled when you hear an unexpected noise?

9. Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?

Reprinted with permission from Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. ™Copyright ©2013 American Psychiatric Association. All Rights Reserved.

Unless authorized in writing by the APA, no part may be reproduced or used in a manner inconsistent with the APA's copyright. This prohibition applies to unauthorized uses or reproduction in any form.
The American Psychiatric Association is not affiliated with and is not endorsing this product.

***

THE MOOD DISORDER

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and... ☐ ☐
   - ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? ☐ ☐
   - ...you were so irritable that you shouted at people or started fights or arguments? ☐ ☐
   - ...you felt much more self-confident than usual? ☐ ☐
   - ...you got much less sleep than usual and found you didn't really miss it? ☐ ☐
   - ...you were much more talkative or spoke much faster than usual? ☐ ☐
   - ...thoughts raced through your head or you couldn't slow your mind down? ☐ ☐
   - ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? ☐ ☐
   - ...you had much more energy than usual? ☐ ☐
   - ...you were much more active or did many more things than usual? ☐ ☐
   - ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? ☐ ☐
   - ...you were much more interested in sex than usual? ☐ ☐
   - ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? ☐ ☐
   - ...spending money got you or your family into trouble? ☐ ☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?

   ☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? ☐ ☐

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ☐ ☐

PHQ-9 modified for Adolescents (PHQ-A)

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were 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

MIDWEST RESEARCH GROUP

ST. CHARLES PSYCHIATRIC ASSOCIATES

4801 WELDON SPRING PARKWAY • SUITE 300
ST. CHARLES, MO 63304

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.

St. Charles Psychiatric Associates
4801 Weldon Spring Parkway, Suite 300
St. Charles, MO 63304
(636) 949-5760