



CHILD/ADOLESCENT INTAKE FORM

(This form should be updated with any information changes. Please complete all items.)

Today's Date: _____ - _____ - _____
Month Day Year

PATIENT INFORMATION

****ARE YOU A LEGAL GUARDIAN OR CUSTODIAL PARENT OF THE CHILD BELOW? ****
 ***IF NOT, FORWARD THIS FORM TO APPROPRIATE PERSON. ***

Child's Name: _____ **Child's SS Number:** _____
First Middle Last

Date of Birth: _____ **Age:** _____ **Sex:** M F

Race (check all that apply): Asian American Indian Black Hispanic/Latino White Native Hawaiian Other _____

School: _____ **Grade:** _____

Name of Parent/Legal Guardian: _____ **Parent/Guardian's SS Number:** _____
Month/Day/Year

Home Address: _____
Street City State Zip Code

Home Phone: (____) _____ - _____ **Parent Cell Phone:** (____) _____ - _____ **Parent Work Phone:** (____) _____ - _____

OTHERS LIVING IN PATIENT'S HOME	DATE OF BIRTH	RELATIONSHIP TO PATIENT (mother, brother, stepsister, grandfather, etc.)

Other Parent's Name: _____ **Other Parent's Phone:** (____) _____ - _____

Other Parent's Address (If Different): _____
Street City State Zip Code

If Divorced, Does Other Parent Have: N/A Sole Custody Shared Custody Visitation Supervised Visitation No Visitation Rights

Relative not Living with Child: _____ **Phone:** (____) _____ - _____

Name of Emergency Contact: _____ **Phone:** (____) _____ - _____

GUARANTOR INFORMATION

Name of Responsible Legal Party/Guarantor: _____
First Middle Last

Guarantor's Relationship to Patient: _____ **Guarantor's Social Security Number:** _____ - _____ - _____

Guarantor's Date of Birth: _____ **Age:** _____ **Gender:** M F
Month Day Year

Guarantor's Address: _____
Street Apt. No. City State Zip

Guarantor's Home Phone: (____) _____ - _____ **Guarantor's Mobile Phone:** (____) _____ - _____

Guarantor's Employer's Name: _____ **Guarantor's Work Address:** _____
Street City State Zip

Guarantor's Work Phone: (____) _____ - _____

REFERRAL SOURCE

How did you hear about us?

HEALTH INFORMATION

Patient's Physician _____ **Physician's Address:** _____
Street City State Zip Code

Describe any medical health problems your child/adolescent currently has. _____

CURRENT MEDICATIONS	DOSE/FREQUENCY	WHEN STARTED? (DATE)	WHO PRESCRIBES MEDICATION?

Describe any serious PAST medical illnesses and injuries with approximate dates. _____

List any prior surgeries with dates. _____

Has the child received prior mental health assessment or therapy? Yes No **If yes, list all dates/periods of treatment below.**

Mental Health Treatment Dates (Begin/End)	Facility/Treatment Provider	Type of Treatment (Medication, Therapy, Hospitalization)	Reason for Treatment/Diagnosis	Was Treatment Successful?

Has the child/adolescent been hospitalized for psychiatric treatment? Yes No **If yes, how many times and when?** _____

What was/were the reason(s) for the child's mental health hospitalization(s) (if applicable)? _____

SERVICES REQUESTED

Please indicate the type of services you are interested in (check all that apply):

- Psychological Testing
 Individual Treatment/Counseling
 Family Therapy
 Diagnostic Clarification
 Learning Assessment
 Personality Assessment
 Court Assessment for Legal Issues
 Other _____

Please describe your primary reason for seeking services. _____

CURRENT SYMPTOMS

Rate the degree to which your children/adolescent has experienced the following symptoms and how long each has occurred.

0 = None, Not at All 1=Mild, Rarely a Problem 2=Moderate, Sometimes It's Difficult 3=Severe, I Can Barely Stand It

Symptom	0-3	How Long?
Prolonged Sadness or Depression		
Loss of Energy		
Social Withdrawal/Avoiding Interaction with Others		
Sleeping Too Much/Sleeping Too Little (<i>circle one</i>)		
Negative View of Future/Hopelessness		
Weight Loss/Gain (<i>circle one</i>)		
Difficulty Making Decisions		
Appetite Increase/Decrease (<i>circle one</i>)		

Symptom	0-3	How Long?
Alcohol Misuse		
Drug Misuse		
Oppositional and Defiant Attitudes		
Decreased Academic Performance		
Conflict (parents, siblings, teachers) (<i>circle</i>)		
Lack of Friends/Negative Friends (<i>circle</i>)		
Sexual Acting Out		
Hallucinations (hearing voices, seeing things) (<i>circle</i>)		

Excessive Joy or Grand Feelings		
Risky Behaviors (splurges, drive fast, stealing) (circle)		
Racing Thoughts		
Pressure to Talk More than Usual		
Abnormally High Physical Activity or Energy		
Prolonged Anxiety/Nervousness		
Fear of Being Criticized in Public or Judged		
Muscle Tension		
Forgetfulness (losing things, forget appointments) (circle)		
Difficulty Relaxing		
Panic or Anxiety Attacks		
Nightmares		
Memories of Traumatic Event(s)		
Bedwetting/Refusal to Sleep Alone (circle all that apply)		
Fear of Objects/Situations/Crowds (circle all that apply)		
Constant and Disturbing Worries		
Rituals-Compulsions (counting, ordering, echoing) (circle)		
Developmental Delay (speech, motor, social skills) (circle)		
Math/Reading/Writing Problems (circle all that apply)		
Failing Grades/Skipping School (circle all that apply)		

Physical Violence/Aggression		
Suspicious Thoughts/Difficulty Trusting Others		
Temper Problems/Rage		
Physical Problems that Increase with Stress		
Fear of Having a Disease		
Short Attention Span		
Difficulty Completing Tasks		
Poor Organization		
Difficulty Following Directions		
Difficulty Sitting Still/Restlessness		
Excessive Talking		
Not Thinking Ahead about Consequences		
Legal Problems/Probation (circle those that apply)		
Twitches/Tics (circle those that apply)		
Worry about Gaining Weight/Restricting Calories		
Inducing Vomiting/Misuse of Laxatives (circle)		
Self-Mutilation/Cutting		
Side Effects from Medication(s)		
Other:		
Other:		

INSURANCE AND WORK INFORMATION

***A copy of patient's insurance card is required to confirm your insurance benefits and file claims.
Please bring insurance card when you return this form.***

Do you plan to use insurance? Yes No **If yes, please complete information below using your insurance card.**

Primary Insurance Company: _____

Name of Insured on Card: _____
First Middle Last

Group Number: _____ **Member Number:** _____

Who is Responsible for Payment of Services? _____
First Middle Last

Relationship of Responsible Party to Patient: _____

Employer and Address: _____
Company Street City State Zip

Landlord: _____ **Phone #:** (____) _____ - _____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of his or her child/adolescent. I further expressly agree and acknowledge that my signature on this document authorizes my child's provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____
Name of Parent/Guarantor Name of Insurance Company

to pay and hereby assign directly to Family Psychological Center all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred, including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services, and I hereby authorize the release of my dependent's pertinent healthcare information to insurance carriers. I understand and agree that I am ultimately responsible for the balance of my dependent's account, regardless of insurance status. I further acknowledge that any insurance benefits, when received by and paid to Family Psychological Center, P.A. will be credited to my account, in accordance with the above said assignment.

I have read all the information on these sheets and have completed all of the answers that apply to me and my dependent. ***I also certify that I am the legal guardian of the child/adolescent and have legal authority to make healthcare decisions for the dependent.*** I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in the above information, including the dependent's address, my employment, any and all contact information, or changes in guardianship/parental custody of the dependent.

Signature of Parent/Guarantor Printed Name of Parent/Guarantor Date

NOTICE OF OFFICE POLICIES

CONFIDENTIALITY

Confidentiality is a fundamental priority. The information you disclose remains confidential except when you provide signed consent to release it (such as to your physician) or when legal or ethical principles apply. Confidentiality must be breached if any form of abuse involving a child, elder, or other incapacitated person is disclosed. Other instances include suicidal intentions, a specific harm against an identified person, or a court order. You should openly verbalize any concerns about confidentiality with your child's treatment professional. By signing below, you acknowledge receiving a copy of the "Patient Notice of Privacy Practices" from the Family Psychological Center, P.A. Which can be obtained from our office or our website at www.fpc-pa.com.

ASSIGNMENT OF HEALTHCARE BENEFITS

I authorize my insurance carrier to assign all health care benefits, if applicable, to Family Psychological Center, P.A. I also authorize release of my child's health care information necessary to process all insurance claims.

PARENT/GUARDIAN INVOLVEMENT

The custodial parent and/or legal guardian **must be present** for the child's initial appointment to give legal consent to provide services and furnish information about the child's symptoms, history, and other pertinent information. If the child has two custodial parents (as in shared custody after a divorce), **both parents must attend** the intake session **or** the parent who does not attend must provide written consent to treat the child. This must be signed at our office *at least 2 days* before the child's initial appointment.

PAYMENT POLICY

Co-payments are to be collected at the time of your child's appointments, before sessions begin. We accept cash and checks only (no credit cards or debit cards). All mental health services provided are directly charged to the patient or responsible party. If your child's provider is contracted with your insurance carrier, we will accept the negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Some billable services may be required that are not reimbursable by insurance but are time consuming for your provider (e.g., writing letters if requested, testing more than allowable hours, court testimony—if in a legal case). We do not bill insurance for court-related evaluations and therapy; services provided in a legal context must be paid in full before services are provided. If non-billable services are requested or required, you will be advised beforehand, if possible. Your payment is expected in full at the time of the service.

CANCELLATION POLICY

Our office requires that if you need to cancel or reschedule your child's appointment, we must receive notice from you at least 24 hours before the appointment. This allows us time to contact another client and schedule in the vacated appointment slot. We reserve the right to charge a \$75.00 fee for a "no show" appointment or an appointment canceled less than 24 hours in advance, which must be collected before your child's next appointment is scheduled. Cancellations must be made in person or by phone. Voicemails must be left on our office line (870-743-6225) if the phone is not answered by our staff at the time you call to reschedule or cancel.

I HAVE READ, UNDERSTAND, AND FULLY AGREE TO ABIDE BY THE ABOVE RELEASE OF HEALTHCARE INFORMATION, PAYMENT ARRANGEMENTS, CANCELLATION POLICY AND FEES, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____
First Middle Last

CONSENT TO CALL

With permission, we remind patients by phone about appointments. If patients are not available, we do not leave messages unless the patient or authorized representative authorizes us to do so. Initial the methods of contact you will permit.

- _____ I consent and authorize The Family Psychological Center, P.A. to call my residence for appointment reminders.
- _____ I consent and authorize The Family Psychological Center, P.A. to leave a message at my residence for appointment reminders.
- _____ I consent and authorize The Family Psychological Center, P.A. to call my cell phone for appointment reminders.
- _____ I consent and authorize The Family Psychological Center, P.A. to leave a message on my cell phone for appointment reminders.
- _____ I consent and authorize The Family Psychological Center, P.A. to call my place of employment for appointment reminders.

I understand and allow The Family Psychological Center, P.A. to contact me by means of the initialed methods above. I understand that phone contact may become known by anyone with access to my phone or caller ID systems.

_____ Patient Name

_____ Date of Birth

_____ Signature of Patient or Authorized Representative

_____ Date

PATIENT NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receiving a copy of the "Patient Notice of Privacy Practices" from Family Psychological Center, P.A. This is available from our office or at www.fpc-pa.com.

Child/Adolescent Patient's Name

Date of Birth

Signature of Patient or Authorized Representative

Date

We appreciate your interest in our professional services and look forward to working with you!

Remember: Take insurance card(s), if applicable, when you return this paperwork to our office.

OFFICE USE ONLY

Date Received _____

Received By _____

Incomplete Sections _____

Notes _____