Patient Information

Provider/Doctor: _____

Date: ____/____/_____

Please Print, *__Bold__ sections are __required__ information*

Full Name (first, middle initial, last): _____

Preferred Name: _____ Marital Status: Single Married Divorced Widowed Other

Date of Birth: ____/____/_____ **Social Security Number:** _____-____-_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Cell Service Carrier (for text message appointment reminders): _____

Email: _____ **Is client a dependent child? Yes No**

Gender: Male Female Other Gender Preference: _____

Responsible Party (if different from client): _____

Relation to client: _____ Legal Guardian: Yes No

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Insurance Information

In order to use your Insurance, please complete this section in its entirety. Please provide your insurance card so we can copy the front and back for filing of claims or inquire about the Self Pay rate.

1. Primary Insurance Company: _____

Policy/Member/ID Number: _____ **Group:** _____

Primary Insurance Holder Name: _____ **Relation to client:** _____

Primary Insurance Holder DOB: ____/____/_____**Phone:** _____

Primary Insurance Holder Social Security Number: _____-____-_____

Employer (if policy through work): _____

OR, **if not using insurance, discussed Self Pay Rate: $_____/session (or until policy deductible met)**

2. Secondary Insurance Company (if applicable): _____

Policy/Member/ID Number: _____ Group: _____

Primary Insurance Holder Name: _____ Relation to client: _____

Primary Insurance Holder DOB: ____/____/_____Phone: _____

Primary Insurance Holder Social Security Number: _____-____-_____

Employer (if policy through work): _____

Other Pertinent Information (For example, Who would you prefer we call for appointment reminders or special circumstances of who not to release information to in the case of changing family dynamics):

_____

_____

Patient Financial Contract

I, _____, am responsible for obtaining prior authorization from my insurance carrier. We will bill your insurance if your provider is on your insurance panel. You are responsible for copayment amounts and deductibles as set by your insurance plan. These payments are due and payable at each appointment. If your insurance changes, you will immediately inform the front office staff. At any time during your treatment, if you become ineligible for insurance coverage, please notify your provider or the office staff. If you are not covered by any insurance plan, or your practitioner is not on your insurance provider panel, you agree to pay for the services in full or at the agreed-upon Self Pay rate at each appointment. If you have insurance that you would like to file yourself, the office staff will provide you with all the information necessary to file your own claims. We check insurance benefits as a courtesy but cannot guarantee coverage.

Initial: _____

Fees for Late Cancellations and/or Missed Appointments: Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours' notice, you may be billed in full for the missed or cancelled appointments. Your insurance company cannot be billed for fees associated with missed or cancelled appointments. We call and/or text clients to remind them of appointments as a courtesy and provide reminder cards for your convenience. If you come in on a cancellation call basis, your original appointment or other previously scheduled appointments will not be cancelled unless you explicitly request such.

Initial: _____

Fees for Additional Non-Covered Services or Assessment: Your provider is responsible for informing you of the assessment costs when you are beyond or outside your benefits. For special modalities of treatment not covered by your benefit plan (for example, psychological testing or family therapy), the agreement should outline your understanding that it is not a covered benefit and state the fees you will be responsible for. There will be a *$30.00* charge for checks returned by your bank for non-payment. When paying in cash, we ask that you have correct change, as we do not keep change in the office. We accept all major credit cards for your convenience, unless otherwise stated by your provider. **Initial:** _____

Release of Information to Obtain Payment for Services: I agree to pay all expenses not covered by insurance or as indicated below. I authorize the release of information to any insurance company for all claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the parties who accept assignment. By signing **I,** _____, agree to all terms and conditions of payment and collections, and in case of default agree to pay all costs of collection or attempts to collect, including but not limited to reasonable attorney fees and court costs. The provider reserves the right to retain a Collection Agent, to notify the Credit Bureau and to initiate proceedings in Small Claims Court. This Agreement is governed by the laws of Alabama. **Initial:** _____

_____ ___/___/_____

Signature **Date**

_____

Printed Name

_____ ___/___/_____

Witness **Date**

I have received a copy of the notice of policies and procedures to protect the privacy of your Personal Health Information _____**(Client)** given a copy of the Health Care Information.
Sign here _____(Client) if client declines to receive a copy, but is aware of and familiar with HIPAA policies and procedures.

Longwood Psychological Center
Child/Adolescent Initial Assessment
Parent Questionnaire

Clinician Notes:

Date: _____

Patient Name: _____ Date of Birth: ____/____/____

Age of Patient: _____ Name of person completing this form _____

Relationship to Patient: _____

Dear Parent: The information that you provide is critical in providing an accurate diagnosis and treatment of the problem. If you require additional space to answer any of these questions, please write on the back of the page and list the number of the question being answered. If you do not know the answer to a question please leave it blank.

I. Please describe, in detail, the present problem (including when the problem started, how often it occurs, what stressors may contribute to the problem, etc.)

Has your child received any previous treatment for the problem? ☐ Yes ☐ No If yes, explain:

II. Medical History:

Name of Pediatrician or Family Doctor: _____
Date last seen: _____

Would you like our findings and recommendations sent to your pediatrician? ☐ Yes ☐ No

Please check any of the following medical conditions for which your child was ever evaluated or diagnosed:

☐ Seizures	☐ Heart Problems	☐ Weight Problems	☐ Head Injury
☐ Asthmatic condition	☐ Chronic Fatigue	☐ Chronic Headaches	☐ Depression
☐ Chronic Hearing Loss	☐ Stomach Problems	☐ Suicidal Thoughts	☐ Surgeries
☐ Other _____			

Please explain any item that you checked and list any medication(s) that were *previously* prescribed.

Allergies (Please list all of your child's allergies)**:**

Current Medications (Please list all of your child's current medications other than above)**:**

Clinician Signature:

_____

Clinician Notes:

III. Past Psychiatric/Psychological History:

Has your child ever received psychiatric services or counseling? ☐ Yes ☐ No If yes, please explain and include dates of service, location, clinician's name.

List any psychiatric or mood medications that your child has been prescribed in the past (if more than 3 medications, use the back of this page):

	Name of medication	Prescribed by	Dose Level
1.			
2.			
3.			

IV: Developmental History:

A: Relating to your child's birth:

Your child's weight at birth: ____lbs. ____oz. Was this a full term birth? ☐ Yes ☐ No If no, explain:

Did either parent use drugs or alcohol at the time of conception? ☐ Yes ☐ No If yes, explain:

Were there any complications with the labor & delivery such as jaundice, infection etc.? ☐ Yes ☐ No If yes, explain:

Were there any problems after birth? ☐ Yes ☐ No If yes, explain:

B. Pre-school/Toddler Temperament: Please check the following items that apply.

☐ Did not enjoy being held	☐ Excessive restlessness	☐ Colic
☐ Feeding problems	☐ Sleep problems	☐ Head-banging
☐ Sensitive to light / noise / texture	☐ Fussy or unhappy	☐ Difficulty bonding

C. Developmental Milestones: Please indicate the approximate age in months when your child achieved the following tasks:

_____ Sitting alone _____ Walking _____ Put words together _____ Toilet trained

D. Unusual behaviors/Speech patterns:

☐ Spinning	☐ Putting things in the mouth	☐ Repeating words or phrases inappropriately
☐ Hand flapping	☐ Sniffing excessively	☐ Saying "I" for "You"

V. School/daycare History:

Did your child attend daycare? ☐ Yes ☐ No If yes, what was their age? ____ Any problems? _____

What were your child's grades on their last report card? _____

What is the name of your child's primary teacher? _____

Clinician Signature:

_____

Clinician Notes:

Name of **Current School:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Name of **Past Schools:**	Dates Attended	Present Grade Placement	Behavior Problems	Learning Problems
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Has your child ever been:
evaluated for a learning disability? ☐ Yes ☐ No If yes, what grade? _____ When? _____

placed in Special Education Classes? ☐ Yes ☐ No If yes, what type of class? _____

_____

tested by the school system? ☐ Yes ☐ No If yes, when? _____

expelled or suspended? ☐ Yes ☐ No If yes, please describe: _____

_____

Does your child have a current IEP (Individual Education Plan)? ☐ Yes ☐ No
Does your child have a current 504 plan? ☐ Yes ☐ No

VI. Legal / Juvenile Court / Alabama State Department of Human Resources (DHR):

Has your child been: Arrested? ☐ Yes ☐ No
Assigned a probation officer? ☐ Yes ☐ No If yes, their name: _____
Jailed? ☐ Yes ☐ No

Has your child: ever appeared in juvenile court? ☐ Yes ☐ No
or other family member ever been reported to DHR? ☐ Yes ☐ No
been assigned a DHR caseworker? ☐ Yes ☐ No
If yes, their name: _____
ever been a victim of child physical or sexual abuse? ☐ Yes ☐ No

If you answered yes to any of these questions, please explain:

VII. Family Medical History:

Is there any family medical history which might be pertinent to the child's therapeutic treatment?

_____

_____

Clinician Signature:

_____

Clinician Notes:

VIII. Family Psychiatric History:
Has any member of your child's family been treated for depression, bipolar disorder, schizophrenia, anxiety, suciidal thoughts, substance abuse problems, learning disabilities, or ADD/ADHD, etc.? Yes No If yes, please explain:

_____

_____

IX. Social / Family History:

Biological mother's full name: _____ Biological father's full name: _____

Biological parents marital status: ☐ Married to each other ☐ Divorced ☐ Separated

If divorced from one another, has either remarried? Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No

If the biological parents are divorced or separated, who has custody of the patient? _____

Type of custody? _____

Stepmother's name: _____

Stepfather's name: _____

List all relatives who presently live in the same household as your child (if more than 5, please list on back of this sheet):

Name	Relationship	Type of Employment / Student Grade Level
1.		
2.		
3.		
4.		
5.		

Please check any of the following stressors that presently affect your child:

☐ Family financial problems ☐ Family relationships ☐ Legal problems
☐ Child rearing problems ☐ Drug or alcohol problems ☐ Abuse behavior
☐ Health problems ☐ Employment problems ☐ School problems
☐ Peer relationships ☐ Frequent change of household ☐ Frequent moves
☐ "Other" problem _____

Please explain how any item you checked affects your child.

Clinician Signature:

_____

Reminder: Please bring a copy of any custody papers to the initial appointment.

Notice of Provider's Policies and Practices

To Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operation

I may *use* or *disclose* your *protected health information* (PHI), for *treatment*, *payment*, and *health care operation* purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could help identify you.
- "Treatment, Payment, and Health Care Operations"
  1. *Treatment* is when I provide, coordinate and/or manage your health care and other services related to your health care. An example of treatment would be when I consult with another healthcare provider, such as your Primary Care Physician or another Psychotherapist.
  2. *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility and/or insurance coverage.
  3. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management, and care coordination.
- "Use" applies only to activities within my office [office, clinic, practice group, etc.,] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as *releasing*, *transferring*, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond for the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an "authorization" from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, and/or family counseling session, which I have kept separate from the rest of your clinical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on

that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. **Uses and Disclosures with Neither Consent not Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse*: If I am treating a child and I know or suspect that child to be a victim of child abuse or neglect, to a duly constituted authority.
- *Adult and Domestic Abuse*: If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subject to physical abuse, neglect, or exploitation, sexual abuse, emotional abuse, I must report this belief to the appropriate authorities.
- *Health Oversight Activities*: If the Alabama Board of Examiners in Psychology, Social Work, Counseling, or Marriage/Family Therapy is conducting an investigation unto my practice, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings*: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court date. The privilege does not apply when you are being evaluated for a third party or here the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety*: I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
- *Worker's Compensation*: I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to work's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. **Patient's Right and Psychotherapist's Duties**

Patient's Rights:

- *Right to Request Restrictions*: You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are seeing me. On your request, I will send your bills to another address.
- *Right to Inspect and Copy*: You have the right to inspect and/or obtain PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy notes unless I make a clinical determination that access would be detrimental to your health. On your request, I will discuss with you the details of the

request and denial process.
- *Right to Amend*: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting*: You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI regarding you and to provide you with notice of my legal duties and privacy policies and practices with respect to PHI.
- I reserve the right to the privacy policies and practices described in this notice.
- If I revise my policies and procedures, I will provide a notice to you by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact our HIPAA Compliance Officer at 1-800-368-1019 for further information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The contact number listed above can provide you with the appropriate address upon request.

VI. Text Message Reminders

Upon implementation of the new text message reminder service, please be advised that your phone service provider might have fees for or associated with sending and receiving SMS/text messages. Also, these reminders are a courtesy, along with reminder calls and reminder cards, and it is your responsibility to schedule and keep appointments, or to cancel with at least 24 hours' notice to avoid a possible late cancellation charge.

VII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice has been in effect since April 14th, 2003, with revisions made February 7th, 2020. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will provide a notice to you by mail.