PEDIATRIC PSYCHOLOGY ASSOCIATES

Aventura • Weston • Coral Gables
Miami-Dade (305) 936-1002
Broward (954) 753-1112
Fax (305) 936-1022

ADULT INTAKE/HISTORY FORM

Name_____ Date_____

Age_____ Birthdate_____ Birthplace_____

Home Street Address_____

City_____State_____ Zip Code_____

Cell_____Home Phone_____ Work_____

Occupation_____

Name of person completing this form (if different from patient): _____

Name and number of person to contact in case of emergency: _____

PRESENTING CONCERNS

Briefly state why you are seeking treatment at this time: _____

_____

_____

_____

How would you describe your current mental state? (Circle all that apply)

Calm	Happy	Tense	Worried	Irritated	Restless
Nervous	Scared	Fearful	Sad	Angry	Guilt-ridden
Unmotivated	Regretful	Disappointed	Confused	Other _____	

MEDICAL HISTORY

Primary care physician's name: _____ Phone #_____

Date of last medical checkup:_____ Was bloodwork completed?_____

What were the findings?_____

Do you currently smoke cigarettes? Yes ___ No ___ If yes, list frequency_____

Hospitalizations, serious illnesses and/or injuries (list date(s) and describe):_____

_____

Please list any medications you are taking and for what conditions/reasons: _____

_____

MARITAL HISTORY

_____ Married _____ Single _____ Divorced _____ Widowed _____ Living with someone

Name of spouse/significant other: _____ Age:_____

Is this your first marriage: Yes ___ No ___ N/A _____ Years Married/Years living together:_____

Briefly describe your relationship with your spouse/significant other:_____

_____

FAMILY HISTORY

Children (if any):

Name: _____ Age:_____

Name: _____ Age: _____

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

Your father's name: _____ Age: ___ Living: ___ Deceased:___

Your mother's name: _____ Age: ___ Living: ___ Deceased:___

If parent(s) is/are deceased, how old were you when this occurred?: _____

Number of years parents are/were married: _____

If divorced, how old were you when parents divorced:_____

Briefly describe your relationship with your parent(s):_____

_____

Siblings (brothers/sisters):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

DEVELOPMENTAL HISTORY

Birth order: _____ Childhood health: ____ Good ____ Fair ____ Poor

If poor, explain:_____

If you were born in another country, how old were you when you moved to the U.S.?_____

Academic history: _____ Excellent _____ Average _____ Poor

If poor, explain:_____

Highest level of education (grade/degree)?_____

Religion primarily raised in:_____

MENTAL HEALTH HISTORY

Previous Psychotherapy/Counseling? No ___ Yes ___ If yes, list date(s) and name of therapist/agency:_____

Previous Psychiatric Treatment? No ___ Yes ___ If yes, list date(s):_____

Psychiatric medication taken currently or in the past? No ___ Yes_____ If yes, date(s) and what kind? _____

Have you ever been hospitalized for mental health reasons? No ___ Yes_____ If yes, list date(s) and place: _____

History of suicidal thoughts or threats: No ___ Yes ___ If yes, date(s)_____

Suicidal gestures and/or attempts: No ___ Yes ___ If yes, list dates and explain how_____

_____

History of physical abuse or assault: No ___ Yes ___ If yes, date (s) _____

History of sexual abuse or assault: No ___ Yes ___ If yes, date (s) _____

History of arrest: No___ Yes___ If yes, please explain _____

History of incarceration: No ___ Yes ____ If yes, please explain _____

History of involvement in lawsuits: No _____ Yes _____ If yes, please explain: _____

_____

Have you ever received treatment for an eating disorder? No _____ Yes _____

If yes, please specify dates and type of treatment: _____

_____

Have you ever received treatment for alcohol and/or drug use? No _____ Yes _____

If yes, please specify dates and type of treatment: _____

_____

History of using alcohol or drugs? No ____ Yes ____ If yes, specify substance, quantity and when was the last time you used substance?_____

Are you currently using alcohol or drugs? No ____ Yes ____ If yes, specify substance, quantity, and frequency of use_____

Family history of substance abuse and/or mental illness?_____

_____

Please note <u>we do not confirm appointments</u>, although we typically provide courtesy appointment reminders through email. Even in the event that you do not receive a courtesy reminder through email, you are still responsible for your appointment.

Please list your email below if you would like a courtesy reminder.

Email address (please write clearly):_____

How were you referred to our office?_____

Phone number of referral source_____

Consent for Treatment

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

Signature_____ **Date**_____

Print Name_____

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Patient Payment Responsibility and Agreement

Name of Patient_____

Please Read and Initial Each Below:

_____ I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment is due at the time services are rendered unless special arrangements have been made. Length of time for therapy sessions are 1 hour for an initial consultation and 45 minutes for follow-up sessions.

_____ Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours' advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours' advance notice, I am financially responsible for the reserved appointment at the standard therapy hourly rate. For testing and extended sessions that are not cancelled within the time frame, I am aware that I am responsible for the number of hours blocked. We may make exceptions and waive the fee at our discretion for emergency or unusual circumstances. There may be a time when your therapist may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame. As a courtesy, the first 2 no shows/late cancellations will be charged at $100.00 and all other no shows/late cancellations will be charged the full therapy rate.

_____ In order to provide effective treatment, consistency of attendance of scheduled appointments is important. Our office policy is that three (3) No Shows or Late Cancellations (less than 24 hours' notice) of scheduled appointments may result in termination of therapy or testing/assessments. If therapy or testing is resumed, then a credit card on file will be required and billed at the time of the cancellation or no show.

_____ In order to be flexible and responsive, many of our therapists are available for phone sessions and to speak with you at times when necessary. Please be advised, however, that all calls exceeding ten minutes will be billed in a pro-rated fashion on the basis of your session fee.

_____ I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and we will always discuss additional charges with you. Other professional services include extended contact via email, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature_____ Date_____

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Acknowledgment of Receipt of HIPAA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ (print name of adult patient, parent or guardian of minor), understand that as a part of my or my family's health care, Pediatric Psychology Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professions who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer (i.e., insurance) can verify that services billed were actually provided, and
- A tool for assessing quality and reviewing the competence of healthcare professionals.

I have been presented with a copy of Pediatric Psychology Associates' Notice of Privacy Policies detailing how my information may be used and disclosed under Federal and State law. I understand the contents of the Notice. Further, I permit a copy of this Acknowledgment to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply. I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this Consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this Consent or revoking this Consent, Pediatric Psychology Associates may refuse to treat me, as permitted by section 164.506 of the Code of Federal Regulations. I understand that Pediatric Psychology Associates reserves the right to change its notice and practices prior to implementation, in according with section 164.520 of the Code of Federal Regulations. Should Pediatric Psychology Associates change its practices, it will send a copy of any revised notice to the address I have provided by U.S. mail, or e-mail, if I agree.

I understand that as a part of Pediatric Psychology Associates' treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and e-mail only to appropriate parties. I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of Patient (Printed): _____Date:_____

Patient, Parent or Guardian Signature: _____

If refused, reason for refusal: _____ Restrictions noted: _____

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Information Regarding Submission of Insurance Claims

(Only complete form if you plan to have PPA file to your insurance company-please read carefully)

Patient's Name:_____

Initial Each Below:

_____ I understand that Pediatric Psychology Associates (PPA) is offering as a courtesy to submit claims for services to my insurance company from the time my insurance information is provided and forward. I understand that I am responsible to pay for all services at the time the service is rendered. I understand that assignment of benefits will be made to the policy holder and that PPA does not accept payment directly from insurance companies. The policy holder/responsible party is responsible for obtaining any authorizations or certifications required prior to services, as well as for follow up on any outstanding claims, including resubmissions. I understand that PPA will not submit insurance claims for services rendered prior to providing PPA with my insurance information.

_____ I understand that PPA does not submit claims for testing or group therapy services. We will provide a detailed invoice once the testing or group services are completed and payment has been received. Due to the multi-disciplinary methodology utilized in the group sessions, it may not be a covered service. It is advisable for you to contact your insurance company directly to obtain a detailed explanation of your benefits and procedures for submitting claims related to group therapy or testing, including any authorizations required prior to testing.

_____ I understand that Telehealth and out of the office services (school visits, etc.) may not be covered by insurance companies. It is advisable to check with your insurance company about this service.

_____ I understand that PPA does not maintain a contracted relationship with any insurance company. Any disputes regarding processing of claims for services are the responsibility of the policy holder.

_____ Kindly accept a photocopy of this authorization as if it were an original executed authorization. I authorize the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims.

_____Insurance policies often change coverage especially during the yearly renewal. I am responsible for informing PPA of any changes to my policy or if I have a new insurance carrier or no insurance at all. There have been times when failure to inform our office has resulted in lack of payment from the insurance company.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature_____

Printed Name:_____ Date_____