DSM1_____(Office Use)

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SUMMIT CENTER FOR MENTAL HEALTH
Child & Adolescent Form (ages 1-17)

CLIENT INFORMATION:

Today's Date: __ _____ Summit Clinician: _____

First Name: _____ Middle: _____ Last: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Ok to Leave message? (circle one)** Yes No

Cell Phone: _____ **Ok to Leave message? (circle one)** Yes No

Social Security Number: _____ Sex: _____ Birth date: _____

Email Address_____ **Ok to email sensitive info?** Yes No

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy ID#: _____ Group #: _____

Phone: _____Employer Name: _____

Insured's Name: _____

Social Security Number: _____Birthdate:_____

Address: _____City, State, Zip: _____

Patient's Relationship to the Insured: Self _____ Spouse _____ Child _____ Other _____

AUTHORIZATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government/insurance benefits to myself or to *The Summit Center for Mental Health, Inc. (SCMH).*

Signed: _____ Date: _____

I authorize payment of medical benefits to *The Summit Center for Mental Health, Inc.* for services provided.

Signed: _____ Date: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different than the patient, please complete and sign:

Guarantor Name: _____DOB: _____

Address: _____City/State/Zip_____

Home Phone_____ Cell Phone _____

Soc Sec #_____Relationship to Patient _____

E-mail Address_____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature_____ Date _____

Name _____ Date _____ Date of Birth _____

Notice of Privacy Practices (NPP) – Short Version

This notice describes how your medical information may be used and disclosed and how you may access this information.

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. This letter is a shorter version of the full, legally required NPP, which you received along with this so refer to it for more information. If you have questions or concerns about the privacy of your information, please talk to our Privacy Officer (see the end of this pamphlet).

We will use the information about your health, which we get from you or from others, for treatment, to arrange payment for our services or for some other business activities referred to as health care operations. At the end of this NPP is a Consent Form to be signed allowing us to use and share your information***. If you do not consent and sign this form, we cannot treat you.***

For treatment purposes, SCMH can use your health information and share it with other professionals who are treating you. For example, SCMH may disclose your personal information to your doctor, at the doctor's request, for treatment by the doctor.

If this information is to be disclosed (sent, shared, released) for any other purposes we will discuss this with you and ask you to sign a separate authorization to allow this.

Of course we will keep your health information private but there are situations when we are required us to use or share it; they are described in the full version of the NPP. Examples of these situations are:

1. A serious threat exists to your health and safety or the health and safety of others. We only share information with a person ororganization able to prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings
3. When required by law enforcement officials
4. Workers Compensation and similar benefit programs

Your rights regarding your health information:

1. You can specify how we communicate with you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask
2. You have the right to ask us to limit what we tell individuals (such as family and friends) who are involved in your care or the payment of your care except if it is against the law, or an emergency.
3. You have the right to look at your health information (such as medical and billing records). You can get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records.
4. If you believe information in your records is incorrect or incomplete, you can ask us to make some changes (called amendments) to your health information. The request must be in writing and sent to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer
6. You have the right to file a complaint with our Privacy Office and with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be in writing. Filing a complaint will not change the health care we provide you in any way.

I hereby acknowledge that I have received a copy of SCMH's Notice of Privacy Practices and that I have been given an opportunity to read it. ***I understand that if I have questions about the Notice or my privacy rights, I can contact the Privacy Officer, Meghan Crandall @ 815-773-0772 ext. 104.***

_____ _____ _____ _____

Patient/Client Signature Date Parent/Guardian Signature Date

Patient/Client Refuses to Acknowledge Receipt _____ _____

Signature of Staff Member Date

Effective date of this notice: April 14, 2003

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

A. OFFICE POLICIES

Confidentiality

- Information in my sessions is confidential EXCEPT if I am threatening to hurt myself or someone else, or if I tell of a child or an elderly person being abused. In any of these cases, the clinician will have to act upon this information to protect me or someone else.

Appointments

_____ Initial

- There is a 24 hour cancellation fee of $75, unless otherwise stated by your provider. When I schedule an appointment, the clinician reserves that time for me and ***if I cannot attend a session, I must give 24 hours notice or I will be charged for this session.***
- The initial visit is considered to be an evaluation only and not a guarantee that treatment will be the result of said visit. This includes the prescribing of medication.
- If I am scheduled for a medication management appointment with a psychiatrist, I understand that I am required to be on time. If I am late, I understand that I ***will be required to reschedule the appointment.***

Medication Refills:

- All requests for prescription refills must be made at least **3 (three)** business days before I run out of medication. The psychiatrist may require me to be seen before refilling a prescription

Payments and Billing:

- I agree to be financially responsible for the full payment of any and all charges and fees associated with this patient's behavioral health services rendered at The Summit Center for Mental Health (SCMH). As a courtesy, and for your convenience, SCMH will bill this patient's insurance carrier(s) when we have been provided with the required accurate insurance information to do so. You agree to be responsible for paying for any and all policy deductibles, co-payments, co-insurances, and uncovered services associated with the behavioral health services provided to this patient at the time the services are rendered (unless the patient's insurance carrier requires us to delay collecting such payments). Although we will verify this patient's insurance coverage prior to providing any behavioral health services, we strongly encourage you to do the same on your own so you know the specifics of this patient's insurance coverage. If SCMH does not receive payment from this patient's insurance carrier within 60 days of submitting a bill for the provided services, I agree to be immediately financially responsible for full payment of this patient's account balance for those provided services.
- I understand that if I choose not to have SCMH bill this patient's insurance carrier for the provided services or if this patient does not have insurance coverage, I agree to assume financial responsibility for any and all charges and fees associated with the services provided to this patient by SCMH providers and/or staff.
- If I do not pay my account then it may be turned over to a collection agency.
- In the event that any check I write is returned NSF (insufficient funds) I agree to pay a ***$25 service fee.***
- I agree to keep a valid credit card on file for billing of balances after insurance has paid their portion, according to my medical plan
- I understand that all credit card charges will include a 3% processing fee. This fee does not go to SCMH, but to the credit card processing company.
- **The parent accompanying the child to session is responsible for any payment unless other arrangements have been made through the billing department.**

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Communication between your SCMH clinician and your PCP can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnoses, treatment plans, progress and medication. You may revoke this consent at any time, except to the extent that action has been taking in reliance upon it and that in any event this consent shall expire in one (1) year from the date of signature, unless another date is specified.

I, _____ _____ _____
Patient/Client (PRINT) Date of Birth Social Security Number

Please check one

☐ I agree to release mental health/substance abuse information to my PCP.

☐ I do NOT give my consent to release any information to my PCP.

Physician's Name: _____

Physician's Address: _____

Physician's Phone: _____ Fax: _____

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____
Relationship/Authority

Information for PCP:

The above named was seen on _____ for _____ by _____
Date Diagnosis/Diagnoses Clinician

Medications prescribed were:

_____

_____

_____

_____

Guardian Name: _____ Relationship to Client: _____

In your own words, tell us why you are seeking care through Summit: _____

_____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

What kind of treatment are you seeking? ☐ Therapy ☐ Medication ☐ Both ☐ Undecided

What is/are your goal(s) for seeking care through Summit? _____

What have you tried that has helped your child? _____

Are the custodial parents divorced? **Y** **N**
If Yes, are both parents aware of the child participating in therapy? **Y** **N**
If not, please explain: _____

Child Intake Symptom Check List:

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

☐Financial difficulties ☐Legal problems ☐Depression ☐Anxiety ☐Problems sleeping ☐Perfectionism
☐Voices in my head ☐Suicidal thoughts ☐Suicide attempts ☐Crying spells ☐Hyperactivity ☐Picky eater
☐Difficulty with relationships ☐Loneliness ☐Anger ☐Loss of appetite ☐Trauma or abuse ☐Sibling rivalry
☐Weight gain ☐Weight loss ☐Eating disorder ☐Self-injury ☐Mood swings ☐Nightmares ☐Sexting
☐Memory loss ☐Agitation ☐Poor concentration ☐History of delayed development ☐Fire-starting ☐Gambling
☐Thoughts of hurting myself ☐Thoughts of hurting someone else ☐Hallucinations ☐Accident-prone ☐Bullying
☐Difficulties at school ☐Problems using or understanding nonverbal communication ☐Viewing Pornography
☐Difficulty with social interactions or situations ☐Poor impulse control ☐Poor grades ☐Cruelty to people or animals
☐School refusal or truancy ☐Vandalism or stealing ☐Problems separating from parents/family ☐Victim of bullying
☐Other symptom(s):_____

Mental Health History:

If your child has received mental health treatment/hospitalization in the past, please tell us:

Provider: _____ When Seen: _____ Helpful? Y N
Provider: _____ When Seen: _____ Helpful? Y N
Provider: _____ When Seen: _____ Helpful? Y N
Provider: _____ When Seen: _____ Helpful? Y N

Please list any mental health diagnoses given to your child in the past: _____
_____
_____
_____

Please list any mental health medications that your child has taken in the **past**: _____
_____
_____
_____

Please list all of your child's **current** medications (including herbs and over the counter medicines): _____
_____
_____
_____

Medical History:

Primary Care Physician: _____ Date of last exam: _____
Medication Allergies: _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

Food/Environmental Allergies: _____

Please list any conditions that your child has been diagnosed with or takes medication for: _____

_____

_____

_____

Medical History Check List:

□Hospitalizations □ Surgeries □ Prematurity □Asthma □ Head trauma □ Seizures □ Fainting

□ Heart murmurs □ Heart palpitations □ Head trauma □ Birth control pill or injection

□ Use of tobacco, alcohol, recreational drugs, or pills (including one time use)

□ Sexual activity in the past 3 years

□ Other: _____

Birth and Development:

Were there complications during the pregnancy? Y N

If so, what happened? _____

Was there tobacco, alcohol, drug, or toxin exposure during the pregnancy? Y N

If so, what exposure occurred? _____

Were there any complications during the delivery? Y N

If so, what happened? _____

Birth Weight: _____ □ Full term □ Premature (_____ weeks early) □ Other: _____

Did you child leave the hospital within 2-3 days of birth? Y N

If not, why was there a delay? _____

Please tell us when your child:

Spoke his/her first word(s): _____ Began using 2-3 word phrases: _____

Began sitting unassisted: _____ Began walking: _____

Completed toilet training: _____

Has your child ever regressed or unexpectedly lost developmental milestones? Y N

If so, what skills were affected? _____

Does your child have any current problems with wetting or soiling him/herself? Y N

Name _____ Date _____ Date of Birth _____

If so, please explain. _____

Social History:

Child's Father: Living? Y N Date of Death: _____ Cause: _____

Age: _____ Occupation: _____ Education: _____

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Child's Mother: Living? Y N Date of Death: _____ Cause: _____

Age: _____ Occupation: _____ Education: _____

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Child's Parents Status:

□ Never Married □ Married □ Separated since _____ (year) □ Divorced since _____ (year)

Child's Siblings: (If additional room is needed for siblings, please use the back of this page.)

Name: _____ Age: _____ Gender: M F

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Name: _____ Age: _____ Gender: M F

Relationship with child is: □ Great □ Good □ Okay □ Fair □ Poor

Please tell us who lives in the home with your child: _____

_____

Family Religion/Belief System: _____

Name of Child's School: _____ Grade Level: _____

Does your child receive any of the following services?

□IEP □ Special education □Speech therapy □ Physical therapy □ Occupational therapy

Does the school system/teachers report any concerns? If so, please explain. _____

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

_____

_____

Family History:

Is there any family history of:

□ ADHD □ Bipolar disorder □ Anxiety □ Depression □ OCD □ Heart problems□ Schizophrenia/Psychosis

□Autism/Asperger's/PDD □ Cognitive/Learning Disabilities □ Legal problems or incarceration

□ Alcoholism □ Drug abuse □ Gambling □ Seizures□Mental health hospitalizations □ Emotional abuse

□ Suicide attempts □ Suicide completion □ Physical abuse □ Sexual abuse □ Domestic Violence

Please list any other mental or medical illnesses that occur in the family: _____

_____

_____

Is there anything else that you would like your child's provider to know? _____

_____

_____

_____

_____

_____

Adolescent Alcohol and Substance Abuse Screening:

If your child is not using alcohol or drugs, please just check here: ☐ Not-Applicable

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

	For each of the following questions indicate "Yes" or "No"	Yes	No
1	Do you feel you are a normal drinker ("normal"- drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended an Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for a few hours, because of other behavior while drinking?		

At what age did you have your first drink?_____ **At what age did you first try a drug?**_____

Please complete the following for each drug you have used: if not applicable, please skip this page.

	Age of 1st	When was	Type of Use (eg, heavy, recreational)

Summit Center Psychiatric Child/Adolescent Intake Form

Name _____ Date _____ Date of Birth _____

	Use	Your Last Use	
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (eg, Ritalin)			
Bath Salts			
Hallucinogens (eg, LSD, Mushrooms, PCP, salvia, ketamine)			
Heroin			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc)			
Other Prescription Medications			
Inhalants			
Cold Medicines/Robo			
Marijuana			
K2/Spice ("Synthetic Marijuana")			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			

the Summit Center

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Credit Card Authorization

For internal use only.

I, _____, authorize The Summit Center to keep my signature on file and to charge my credit card listed below for:

All patient balances for services rendered once the claim has been processed by my insurance company. I understand that SCMH will charge my card for any outstanding balances, including late cancellation and no-show fees when assigned, without additional authorization. I also understand that there will be a 3% charge on any credit card transactions.

I certify that the below information is true and accurate and that I am an authorized user on the credit/debit card below.

Recurring charges for services rendered for the following family members:

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

**We do not accept American Express

Billing Address:_____City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____

X Cardholder Signature: _____ Date: _____ Cardholder contact number: _____