Child/Adolescent Information Sheet

Provider: Judith Allston, LCSW
Today's Date:_____

Child's Full Name (first, middle initial, last):_____

Street Address:_____

City/State/Zip:_____

Home Phone:(___)_____ Sex:_____ Age:_____

Birthdate:_____ Social Security Number:_____

Highest Grade Completed:_____ Current School:_____

Mother's Name:_____

Street Address: _____ City/State/Zip _ _____

Home Phone:(___)_____Work Phone:(___)_____

Cellular Phone:(___)_____ Pager:(___)_____

Birthdate:_____ Social Security Number:_____

Occupation:_____ Employer:_____

Father's Name:_____

Street Address: _____ City/State/Zip _____

Home Phone(___)_____ Work Phone:(___)_____

Cellular Phone:(___)_____ Pager:(___)_____

Birthdate:_____ Social Security Number:_____

Occupation:_____ Employer:_____

Who should be contacted in case of emergency?_____

Phone:(___)_____ Relationship to child:_____

There may be occasions in which our office needs to contact you concerning your appointments, billing problems, or any other situation relating to your visit at our office. Please indicate if you give our office permission to leave messages (on an answering machine or with anyone that answers the phone) at the following locations:

Home Phone:	Yes	No
Work Phone:	Yes	No
Cell Phone:	Yes	No

Other numbers we may use to contact you:_____

_____

Are the child's parents separated or divorced? YES NO If YES, when?_____

Who has legal custody of this child? Mother Father Other_____

List the child's brothers/sisters and/or stepsiblings:
Name Age Living with Child? Problems

Who referred you?_____ Phone:(___)_____ May I contact him/her to acknowledge the referral? YES NO

Briefly describe your reason for seeking help now:_____

How long has this been a problem ?_____

Primary Care Physician:_____ Phone:(___)_____ Does the child have any legal problems? YES NO (If YES, please explain)_____

Do you want this office to file insurance claims for you? YES NO
If "YES," complete this section. If "NO," skip this section.

Have you called your insurance company to pre-authorize these services? YES NO

Primary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

Secondary Insurance:_____ Policyholder:_____

Relationship to Policyholder:_____ Policyholder's Date of Birth:_____

Policy/ID#:_____ Group #:_____

Claims Address:_____

Who is responsible for the bill?_____

Will you be paying today by: Check_____ Cash_____ Credit Card_____

CONSENT TO EVALUATE/ASSESS/TREAT A MINOR

Patient:_____Date of Birth_____

Address:_____

I hereby authorize _____to evaluate, assess, and/or treat
(Please print provider's name)
my child/ward, _____.

Signature:_____ Date:_____
Parent or Legal Guardian

Witness:_____ Date:_____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information . Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can do protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Judith Allston, LCSW
Licensed Clinical Social Worker

I, _____, understand and have been provided a copy of Ms. Allston's Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature or Parent if Minor or Legal Charge Date
If Legal Charge, describe representative authority: _____

PROFESSIONAL PSYCHOTHERAPY ASSOCIATES
1002 Bradford Way Kingston, TN 37763
Phone (865) 376-1585 FAX (865) 376-1587

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Judith A. Allston, LCSW to release to my insurance company and/or insurance plan management company information requested on the HCFA-1500 claim form and/or the plan management company's outpatient treatment report for the purpose of pre-authorizing services and/or processing claims for reimbursement of services rendered by above-named therapist. I also authorize above-named therapist to release the information necessary to secure full payment of my account through other parties, such as a collection agency/credit bureau or court of law, if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign and direct my Insurance Company and/or insurance plan management company to pay Judith A. Allston, LCSW such amount as may be payable pursuant to the provision of my contract.

I also authorize above-named therapist to initiate a complaint to the Insurance Commissioner on my behalf if my insurance company fails to respond to a claim or to pay a claim in a timely fashion.

Date:_____ Patient or Guardian's Signature:_____

PAYMENT AGREEMENT

I accept responsibility for payment of fees for services provided to myself and/or my dependent by Judith A. Allston, LCSW. I understand and agree that having health insurance coverage does not relieve me of full responsibility for all charges, even when the therapist agrees to accept direct payment of benefits from the insurance and/or the plan management company. I understand that my insurance benefits may not pay for all charges incurred by my dependent or myself. I understand that I may be charged for appointments not canceled 24 hours in advance and agree to pay those charges. I further agree to pay all charges (such as collection agency commissions, attorney's fees, court costs, returned check charges) incurred by above-named therapist in the pursuit of payment for my delinquent account balance in addition to the full balance of my account. I also understand that interest charges may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Date:_____ Patient or Guardian's Signature:_____

JUDITH A. ALLSTON, L.C.S.W., B.C.D.
CLINICAL SOCIAL WORKER

In preparation for your first appointment, I would like to provide you with answers to some common questions you might have about our office procedures and what to expect from your initial consultation.

People seek counseling or psychotherapy for many different reasons – marriage or family problems, job or financial stress, depression, anxiety, or traumatic events in the past or present to name a few. The appropriate course of treatment depends on the nature and history of your personal concerns, so today's session will focus on obtaining information about your reasons for seeking therapy and relevant background information. Please try to be as frank and direct as you can in expressing your concerns, as this will allow us to be more effective in working together to formulate a helpful treatment approach. Also, please do not hesitate to ask any questions you have about office or billing procedures or the process of therapy itself.

The confidentiality of therapy is protected by state law. This means that anything discussed or disclosed in the course of treatment is held in the strictest confidence. Should you wish me to release information to a third party, I will obtain your written consent to do so. That consent may be revoked by you at any time.

There are three circumstances under which a psychotherapist may be required to release information without client consent: 1) if the psychotherapist has clear reason to believe that a client poses imminent bodily danger to him or herself or to a specific third person; 2) if the psychotherapist has reason to believe that a minor child is being or has been abused or neglected; and 3) if a judge specifically orders the release of records.

If you wish to use insurance to assist with treatment costs, please note that many insurance and managed care organizations require either limited or full release of clinical information to authorize payment of claims and to document medical necessity for services provided. The information required may be limited to diagnosis and dates of service or may be as extensive as an on-site review of all records relating to the case. Please feel free to speak with me or to contact your insurance carrier or managed care organization if you have questions about these procedures. Your sense of privacy is very important for successful treatment, so I strongly encourage you to raise any concerns you have about confidentiality or its limitations.

For routine messages, you may leave a message for me on **my voice mail (376-1585 extension 104)**. For an urgent message, please leave a message on my voice mail and follow the prompts so that I may be paged. In the event that I am out of town or otherwise unavailable, my voice mail greeting will advise you of the name and number of the clinician who is providing emergency coverage. You may also seek emergency treatment at any time by dialing 911 or consulting your area hospital Emergency Room.

Fees will be discussed in your initial session. If you wish to pay for sessions on a fee-for-service basis, full payment is expected at the time of the appointment unless other arrangements are made. Mastercard and Visa payment options are also available. If you wish to use your health insurance to help with the cost, co-pay and deductible payments are expected at the time of the appointment. You will be responsible for any unpaid balance with the exception of circumstances or fees specified in provider agreements with your insurance or managed care company. Statements are issued once monthly. Should you have any questions regarding your statement or insurance claim, please contact Ms. Debra Patterson, office manager, at 376-1585.

Appointment times are reserved specifically for you, and 24 **hour notice is requested if you are unable to keep a scheduled appointment**. You may leave a message at 376-1585 if you must cancel a scheduled appointment. **Should you fail to give such notice, a $40 fee will be charged, which will not be reimbursed by insurance.**

I recognize that from time to time circumstances may arise which impact one's capacity to meet payments on the agreed upon schedule. Should this occur, let me know. I will be happy to work with you on a payment plan which is manageable for you. However, in the event a good faith effort is not made toward payment of services, I reserve the right to turn delinquent accounts over for collection.

I hope this information is useful in explaining basic policies. Please keep a copy of this document for your records. Your signature below indicates that you have read this document, agree to the client responsibilities outlined, and have received a copy.

Patient Signature _____ Date _____

Custodial Parent or Guardian _____ Date _____

Psychosocial History -- CHILD

Thank you for taking the time to fill out this information. It will be helpful to your therapist in giving you the best treatment. Professional Psychotherapy Associates does not discriminate against any individual based on race, creed, religion sex, age, handicap, or national origin. If you need help filling this out, please tell the receptionist.

Client Name:_____ Age:____
School:_____ Grade:____
Name of parent/guardian:_____
Others in household:_____

_____

_____

Other important people in child's life:_____

_____

Emergency contact person and phone:_____
Mother is: single married divorced separated remarried living together widow
Father is: single married divorced separated remarried living together widow

Previous marriage(s) of mother:_____
Previous marriage(s) of father:_____
Briefly describe your reason for contacting us_____

_____

How long has this been a problem?_____
Why did you decide to seek help now?_____

_____

How do you, as the parent, deal with behavior problems?_____

_____

Has the child had counseling or treatment before? Yes____ No____ Where? and was it helpful?_____

_____

What other attempts have been made to handle this problem?_____

_____

Please list with phone number any other persons it might be helpful for us to contact in order to assist you. (We will not contact anyone without a specific written Release of Information.)_____

_____

Client Name_____

	Does not apply	Not Very Serious	>>>>>>>>>>>			Very Serious
Overall, how serious is this problem for you?		1	2	3	4	5
How serious for the child?		1	2	3	4	5
How seriously has this problem affected:						
Family	_____	1	2	3	4	5
School Performance	_____	1	2	3	4	5
Friendships	_____	1	2	3	4	5
Legal situation	_____	1	2	3	4	5
Health	_____	1	2	3	4	5
Anxiety level/ Nerves	_____	1	2	3	4	5
Mood	_____	1	2	3	4	5
Eating habits	_____	1	2	3	4	5
Sleeping habits	_____	1	2	3	4	5
Ability to concentrate	_____	1	2	3	4	5
Ability to control Temper	_____	1	2	3	4	5
Spirituality	_____	1	2	3	4	5

What is your spiritual orientation?_____
What church or group do you attend?_____
What are your child's hobbies and leisure activities?_____
_____
How much time per day is spent watching television or playing video games?
_____
How many hours on average does the child sleep?_____

Client Name_____

Health History

Family Physician_____ Phone No._____
Address_____
Date of last medical exam_____ Future Appointment_____
Specify any physical limitations_____
Allergies_____
Pharmacies used_____

Mark any of the following health problems your child have ever experienced with a check. Mark an "O" if it has been as health problem for others in the family.

____Heart Disease	____Pneumonia	____Sexually Transmitted
____Cancer	____Bronchitis	Disease
____Diabetes	____Asthma	____PMS/Menstrual
____Stroke	____Arthritis	____No. of Pregnancies
____Seizures	____Hepatitis	____AIDS/HIV Positive
____Ulcers	____Cirrhosis	____Kidney Problems
____Head Injury	____Broken Bones	____Stomach/Intestinal
____Thyroid problem	____Emphysema	Disease
____Rheumatic Fever		

Other conditions:_____
Surgeries and date:_____
Has child been in the hospital in the last 6 months?_____ If so, describe reason.
_____
If child is on medication, please indicate name, dosage:_____
_____
Are inoculations up to date? _____Yes _____No
What over-the-counter medication does the child regularly take, if any?_____
_____
Does child use tobacco?_____ What type and how often?_____
Does your child use illegal drugs or alcohol?_____
How much caffeine does your child consume on an average day? (coffee, some soft drinks, tea, chocolate)_____
If child's parents or siblings are deceased, please list when and how they died:___
_____
_____

Client Name_____

Symptom Check List
(Child)

Sleep problems_____
Appetite problems_____
Weight gain_____
Weight loss_____
Excessive crying/sadness_____
Anger/temper tantrums_____
Fear going to school_____
Loss of interest/pleasure_____
Interrupts others_____
Confusion_____
Sexual problems_____
Won't sleep alone_____
Doesn't listen_____
Oppositional/defiant_____
Isolates/withdraws_____
Suicidal_____
Accident prone_____
Running away_____
Short attention span_____
Nightmares_____
Sudden change behavior_____
Truancy_____
Shyness_____
Lying_____

Regressive behavior_____
Clinging_____
Restlessness_____
Obsessions & type_____
Compulsive behavior_____
Argumentative_____
Physical violence_____
Irritability_____
Forgetfulness_____
Cruelty to animals_____
Cruelty to people_____
Memory problems_____
Fidgety_____
Hyperactivity_____
Tobacco use_____
Self-Injurious behavior_____
Setting fires_____
Stealing_____
Excessive talking_____
Wetting/soiling_____
Excessive worries or fears_____
Phobias/fears_____
Loses things_____
Doesn't get along with peers/siblings

Somatic problems:_____
Other problems:_____
Comments on the above:_____
_____

Client Name_____

DEVELOPMENTAL HISTORY

Pregnancy: Normal_____ Complicated by_____

Alcohol and/or drug abuse_____ Smoking_____

Maternal illness_____

Birth: Spontaneous vaginal delivery_____ Cesarian section_____

Complicated by_____

Full term_____ Premature/post mature_____

Apgar score(if known)_____

Birth Weight_____ Birth Length_____

Comments:_____

_____

_____

Developmental Milestones:

1. At what age did your child sit up?	____3-6 months	____7-12 months
	____Over 12 months	____ Don't Know
2. At what age did your child crawl?	___6-12 months	____13-18 months
	___Over 18 months	____Don't Know
3. At what age did your child walk?	___Under 1 year	____1-2 year
	___2-3 year	____Don't Know
4. At what age did your child speak single words (other than "mama" or "dada")?	____9-13 months	____14-18 months
	____19-24 months	____25-36 months
	____37-48 months	____Don't Know
5. At what age did your child string two or more words together?	____9-13 months	____14-18 months
	____19-24 months	____25-36 months
	____37-48 months	____Don't Know

Client Name_____

Sleeping Habits:

_____sleeps quietly
_____sleeps restlessly
_____sleeps alone
_____problems going to bed
_____easy to awaken
_____difficult to awaken
_____hours of sleep per night

_____nightmares
_____fears
_____sleepwalking
_____bed wetting
_____soiling
_____wakes up cheerful
_____wakes up grouchy

Comments:_____
_____
_____

Personal Habits:

bowel control_____ age begun_____ established_____
bladder control_____ age begun_____ established_____
dressed self_____ feeds self_____ brushes teeth_____

Speech, Hearing, Vision:

Hearing

normal_____ hearing problem_____ age noted_____
audiometric testing_____ age_____
diagnosis_____
therapy_____ progress_____
results_____
_____

Speech

normal_____ defects of speech_____ age noted_____
diagnosis_____
therapy_____
progress_____
results_____

Vision

normal_____ problem_____ age noted_____ diagnosis_____
glasses_____
other treatment_____
progress_____
_____
results_____

Name_____ _____
(Signature of person completing this form) (Relationship to child)

Date_____