CHILD/ADOLESCENT
NEW PATIENT
PACKET

PATIENT & CONTACT INFORMATION

TODAY'S DATE ___________________ DOCTOR YOU WILL BE SEEING _______________________

NAME: ____
(first) (middle) (last)

Nickname or Name you go by: ____________________ AGE: ____________ **DATE OF BIRTH**: ______________

ADDRESS: ____
(street) (apt/suite) (city) (state) (zip code)

Primary Phone # ______________________________ **IS A:** [ ] cell [ ] home [ ] work [ ] other ____________

Secondary phone # ____________________________ **IS A:** [ ] cell [ ] home [ ] work [ ] other ____________

Email Address (needed for patient portal): ____

Please Choose One: We provide a *courtesy* reminder for your appointments either by: [ ] Email **or** [ ] Text

SEX: [ ] M [ ] F **Gender Identity**: ___________________ Employer (if working): ________________________

RACE: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] White

[ ] Native Hawaiian or Pacific Islander [ ] Other Race: _________________

ETHNICITY: [ ] Hispanic or Latino [ ] Not Hispanic or Latino

List Below the Child's

Parents/Guardians/Step Parents (Name):	Siblings (Names & Ages):

Previous or Referring Provider*: ____

Primary Care Provider*: ____

please fill out a consent to release information for these providers^^ for continuity of care

Other family members seen here: ____

EMERGENCY CONTACT: Please list someone other than person(s) bringing child to appointments):

____

(name) (relationship) (phone #)

PREFERRED PHAMARACY: (please let your doctor know if certain prescriptions are to be 90 day or mail order)

____

(store name) (address) (phone)

INSURANCE INFORMATION

[ ] NO COVERAGE / SELF PAY – *if you are opting out of using your insurance please fill out our opt-out form*

[ ] FILE TO MY INSURANCE – *Please provide us with a current and up to date copy of your insurance card at each visit*

INSURANCE CARRIER ________________________________**POLICY TYPE**__________________________

MENTAL HEALTH COVERAGE (if different than main carrier) ____________________________________

Member ID______________________________ Person # _______ Group #________________________

Customer Service Phone # ______________________ Mental Health Phone # ______________________

Pharmacy Benefits Administrator ___________________________ PBA Phone # _____________________

Rx ID # ___________________ Rx BIN ________________ Rx Group ____________ Rx PCN ___________

Policy Holder/Subscriber: Name____________________________ Relationship to patient______________

Subscriber's Address____

Subscriber's Date of Birth________________ Subscriber SS# __________________ Sex [ ] M [ ] F

Person responsible for bill (if different than patient) ____

Address to send bills to ____

Please read thoroughly then sign and date stating that you have read and agree to abide by all office policies for Peace Psychiatry

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices is attached to this clipboard, if not, our office staff can provide you with one. It is also posted on our website at www.peacepsychiatry.com. By signing below, you acknowledge receipt of this notice and/or know how to access this notice. You may refuse to sign this acknowledgement; however, should you refuse to sign, Peace Psychiatry, PLLC will not be able to file to your insurance and you would be fully responsible for all charges.

MISSED APPOINTMENT POLICY

Peace Psychiatry charges for missed appointments or any appointment that is canceled with less than 24 hours' business day notice. You must contact the front office staff to cancel and reschedule appointments. Appointment reminders (texts/emails) are provided only as a courtesy. We ask that you do not solely rely on reminders, you are ultimately responsible for keeping a record of the day and time of your appointments. It is our policy to collect the missed appointment fee prior to rescheduling a new appointment. *Your doctor has the right to close your chart and refer you elsewhere if you do not follow up as recommended.*

FINANCIAL & INSURANCE POLICY

Our practice is committed to providing the best treatment for our patients and we charge the usual and customary rates for our area. **Full payment is due at the time of service.** We accept cash, check, money order, Visa, MasterCard, Discover, or American Express. Our office does not intervene with family disputes; it is the guardians' responsibility to provide payment at the time services are rendered.

Our providers are credentialed and have contracts with several insurance networks. It is your responsibility to check if your doctor is in-network with your mental health carrier. To find out this information, we recommend you call your insurance company prior to your visit. We file with primary insurance only and do not file out-of-network or secondary insurance claims. If we are not contracted with your insurance carrier, you are responsible for full payment at the time of service. If your insurance requires an authorization for your visits, you are responsible to obtain that authorization prior to your appointment. If you have a deductible, you are responsible for paying for your portion in full at the contracted rate for your insurance carrier until you have met your deductible obligation with that carrier. If your insurance carrier requires a co-payment or a co-insurance, this is to be paid at each visit.

You are responsible for payment of services rendered regardless of any determination made by an insurance company. Insurance will not pay for missed appointments. Unless canceled at least 24 hours (business day) in advance, it is our policy to charge the office visit rate for the missed appointment. It is also your responsibility to notify the office if you have a change in insurance coverage and provide us with an up to date insurance card at each visit. We collect the patient responsibility (portion/copay) at the time services are rendered. For this reason, we recommend you call your insurance and find out your mental health office visit benefits prior to your appointment, thenceforth you will be prepared to pay your portion. Please let us know if you have any questions or concerns regarding our financial policy.

By signing below, you have read and agree to all of the above and the following statements:

The information I have provided to the office is true, to the best of my knowledge. I authorize Peace Psychiatry, PLLC to release any information required to process my claims and to have my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance or denial of claims. I understand that Peace Psychiatry has the right to refuse services if I violate any of the office policies.

Signature: ____ Date Signed: ____________________

FAMILY INFORMATION

This child lives with ____.

PARENT/GUARDIAN 1
NAME ____ AGE/DOB: ___________________

ADDRESS (IF DIFFERENT THAN PATIENT) ____

PHONE #_________________________________ EMAIL ____

PARENT/GUARDIAN 2
NAME ____ AGE/DOB: ______________________

ADDRESS (IF DIFFERENT THAN PATIENT) ____

PHONE #_________________________________ EMAIL ____

PARENT/GUARDIAN 3 (if needed)
NAME ____ AGE/DOB: ___________________

ADDRESS (IF DIFFERENT THAN PATIENT) ____

PHONE #_________________________________ EMAIL ____

PARENT/GUARDIAN 4 (if needed)
NAME ____ AGE/DOB: ___________________

ADDRESS (IF DIFFERENT THAN PATIENT) ____

PHONE #_________________________________ EMAIL ____

SOCIAL HISTORY:

	YES	NO
Is there any history of abuse (physical/sexual/emotional)?		
Is this child/adolescent sexually active?		
Has this child/adolescent ever had interactions with the juvenile justice system?		
If yes, explain:		
Are there any problems with alcohol / tobacco / illegal substances?		
Has Department of Social Services / Child Protection Services been involved with this child?		
If yes, explain:		

List any hobbies or interests: ____

____

____

EDUCATION:

Goes to _______________________________ School and currently in the _______________________ grade.

	YES	NO
Has this child/adolescent had to repeat an academic year?		
Have there been any disciplinary problems in school?		
If yes, explain:		
[ ] suspensions [ ] detentions [ ] expulsion [ ] truancy [ ] other		
Is there any history of learning disabilities?		
If yes, explain:		
Has the child/adolescent ever received any special educations services / IEP (Individual Education Plan) / 504 Plan?		

MEDICAL HISTORY:

Does the child/adolescent have any history of:	YES	NO
1. Chest pains or heart problems		
2. Seizures		
3. Operations / Surgeries		
4. Head Injuries / Loss of Consciousness		
5. Frequent Dizziness / Light headaches / Fainting		
6. Frequent headaches		
7. Hospitalizations		
8. Other ongoing medical issue(s) **if yes, please explain below**		
9. Reaction to drugs or food (ex: allergies) **if yes, please explain below**		
10. Non-routine diagnostic tests such as brain MRI, head CT scan, or EKG?		

Please explain “ongoing medical issue” from question 8: ____

____

Please explain “reactions” from question 9: ____

____

List all medications (including supplements/vitamins) child is ***currently*** taking:

Medication **Dose** **Date Started** **Response**

____

____

____

____

DEVELOPMENTAL HISTORY:

	YES	NO
1. Any problems with pregnancy or delivery of the child/adolescent?		
If yes, explain:		
2. Any problems with development or reaching the following milestones:		
Growth (height / weight / head circumference)		
Walking / crawling / moving / coordination		
Speech / Talking		
Bowel / Bladder Function		
Social Development / Interaction		
Hearing / Vision		
Onset of Puberty		
Other (please explain)		

HABITS:

Are there any problems with:	YES	NO
Sleep		
Appetite / Eating / Nutrition		
Exercise / Activity Level		

SOCIAL INTERACTIONS:

This child/adolescent:	YES	NO
Gets along with others the same age		
Gets along with adults		
Makes friends easily		
Is able to keep friends		
Has appropriate social skills		
Has problems with peer pressure		
Has problems with aggression (i.e., fights / threats/ etc.)		
Is destructive of property		
Steals		
Lies		
Often loses temper / has tantrums		
Often argues with adults		
Actively defies / refuses to comply with rules		
Does things to deliberately annoy others		
Blames others		
Often touchy or easily annoyed		
Often angry or resentful		
Often spiteful or vindictive		
Is bullied or bullying		
Has issues due to gender identity / sexual orientation		

ATTENTION:

This child/adolescent often:	YES	NO
Fails to give close attention to details or makes careless mistakes		
Has difficulty sustaining attention		
Does not seem to listen when spoken to directly		
Does not finish tasks		
Has trouble organizing		
Avoids tasks that require sustained mental effort		
Loses things		
Forgets things		
Is easily distracted		

HYPERACTIVITY / IMPULSIVITY:

This child/adolescent often:	YES	NO
Fidgets or squirms		
Has trouble sitting still		
Runs or climbs excessively		
Has difficulty doing things quietly		
Has excessive energy		
Talks excessively		
Blurts out answers		
Has difficulty waiting		
Interrupts or intrudes		

MOOD / ANXIETY:

This child/adolescent often:	YES	NO
Has mood swings		
Is unhappy / sad		
Has low self-esteem		
Has no energy / motivation		
Does not like change / wants things just right		
Easily frustrated or overwhelmed		
Nervous / Worrying / Fearful		
Does things over and over		
Has unpleasant thoughts that he / she can’t get rid of		
Feels his / her mind is always active and unable to relax		
Has talked about or threatened self-harm or suicide		
Has bizarre or odd behaviors		

FAMILY HEALTH HISTORY:

Please list which biological family members, if any, have a history of the following psychiatric or medical illnesses:

WHAT	YES	NO	WHO
Bipolar Disorder			
Depression			
Anxiety			
ADD or ADHD			
Schizophrenia			
Alcohol or Drug Problems			
Chest pain, heart problems, or sudden cardiac death			
Seizures			
Autism or any learning disabilities			
Other:			

PSYCHIATRIC HISTORY

Individual or Family Therapy

Mental Health Provider **Dates** **Response**

____

____

____

Psychiatric Hospitalizations

Location **Dates** **Reason Hospitalized**

____

____

____

Past Psychiatric Medications

Medication **Does** **Dates Used** **Response/Side Effect**

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