CHILD REGISTRATION FORM

The Independent Practitioners
at the Barn on Sycamore

For office use only:
CL: 01 02 03 04 05 06
DX: _____
MCP:_____

(Please Print)

CLIENT INFORMATION:

Name _____
(Last) (First) (Middle) (Preferred Name/Nickname)

Address _____
(Street) (City) (State) (Zip Code)

Email Address_____ Home Phone (_____)_____

Work Phone (_____)_____ Mobile Phone (_____)_____

Emergency Contact: Name & Phone Number_____ Relationship _____

SS#_____ Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Civil Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Race: ☐Asian ☐Black ☐Caucasian ☐Hispanic ☐Native American ☐Other

PARENT/GUARDIAN (If the client is a minor):

Name: _____Custody held by: _____

Address (if different from your child): _____

GUARANTOR INFORMATION: Please provide information regarding person(s) responsible for payment of amounts not covered by insurance. Be prepared to supply your insurance card(s) at time of first visit so that a photocopy can be taken. Thank you.

Bill to Parent(s)/Guardian(s) (*if client is a minor*): _____

Address (if different from client): _____
(Street) (City) (State) (Zip Code)

Name of Insurance Policy Holder: _____ Relationship to client: ☐ Self ☐ Spouse
(as it appears on insurance card) ☐ Parent/Guardian

Policy Holder's Employer: _____ DOB: _____ SS# _____

PRIMARY INSURANCE:

Insurance Carrier: _____ ID# _____ Group # _____

Is pre-authorization required? ☐ Yes ☐ No ☐ Not sure What is your deductible? _____

Do you have a co-pay? ☐ Yes ☐ No ☐ Not sure If yes, what is the amount? _____

Annual/lifetime limit: _____ Does it cover mental health services? ☐ Yes ☐ No ☐ Not sure

SECONDARY INSURANCE:

Insurance Carrier: _____ ID# _____ Group # _____

Is pre-authorization required? ☐ Yes ☐ No ☐Not sure What is your deductible? _____

Do you have a co-pay? ☐ Yes ☐No ☐ Not sure If yes, what is the amount? _____

Annual/lifetime limit: _____ Does it cover mental health services? ☐ Yes ☐ No ☐ Not sure

NAME & RELATIONSHIP OF FAMILY MEMBERS:

_____

_____

_____

EDUCATIONAL HISTORY OF CLIENT:

School Attended/Attending _____Graduation Date_____

University/Tech School _____Graduation Date_____

HEALTH INFORMATION:

Have you had any previous mental health treatment elsewhere? □Yes □ No

If yes, where and with whom? _____

List any significant health concerns: _____

_____

_____

Do you smoke? □ Yes □ No Packs per day? _____ For how long? _____

Do you use alcoholic beverages? □ Yes - If yes, how often? _____ □ No

Do you use illegal drugs or substances? □ Yes - If yes, how often? _____ □ No

Are you currently under the care of a physician? □ Yes □ No

Physician: _____ Phone: _____

Please list medications you are currently taking:

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Were you referred to this office for services? If so, by whom: _____

INSURANCE AUTHORIZATION

I hereby authorize my therapist to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process claims on my behalf. In addition, I hereby authorize direct payment of medical insurance benefits to my therapist for services rendered.

Signed: _____Date _____

(Client – Parent – Guardian)

DEVELOPMENTAL HISTORY

_____ Yes _____ No Was pregnancy planned?

_____ Yes _____ No Were there pregnancy complications?
If yes, please explain: _____
Complications of birth/delivery: _____

_____ Yes _____ No Is child adopted?
If yes, at what age: _____

_____ Yes _____ No Problems with feeding, eating, sleeping?
When did problems start? _____
Duration of issues? _____

_____ Yes _____ No Have there been any physical or emotional separations (i.e. death, hospitalizations, depression) between child and caretaking adult during the first 26 months of life?

_____ Yes _____ No Is there, as far as you know, any possible history that could be considered abusive? If yes, please describe: _____
_____

If it is hard to remember specific ages, please simply check the problem areas you feel were/are advanced or slow/delayed in development:

Age he/she:		Does he/she:		Is he/she:	
Head held up	_____	Have blank spells	_____	Shy/timid	_____
Crawled	_____	Rock	_____	Affectionate	_____
Walked with help	_____	Shun attention	_____	Well coordinated	_____
Used sentences	_____	Have temper tantrums	_____	Impulsive	_____
Fed self	_____	Have falling spells	_____	Right- or left-handed	_____
Dressed alone	_____	Have unusual fears	_____	Clumsy	_____
Turned over	_____	Bump head	_____		
Sat up	_____	Hold his/her breath	_____		
Walked alone	_____	Show dare-devil behavior	_____		
Was weaned	_____				
Said “no” to everything	_____	Have sleeping problems	_____		
Smiled at parents	_____	Have eating problems	_____		
Pull up at crib	_____				
Said 4-10 words	_____				
Helped with dressing	_____				
Dry during day	_____				
Dry during night	_____				

Previous testing or therapy _____

Dates/locations _____

Findings _____

SYMPTOM CHECKLIST

Child's Name _____ Date _____

Completed by _____ Relationship _____

Please place a mark in the appropriate column for each symptom as it pertains to your child. On a separate sheet of paper, please give a brief description of your child's behavior regarding each symptom marked as moderate or severe.

	None	Mild	Moderate	Severe
1. Lack of impulse control				
2. Self-destruction				
3. Destruction of property				
4. Aggression towards others				
5. Consistently irresponsible				
6. Inappropriately demanding and clingy				
7. Stealing				
8. Deceitful				
9. Hoarding				
10. Inappropriate sexual conduct and attitudes				
11. Cruelty to animals				
12. Sleep disturbance				
13. Enuresis and encopresis				
14. Frequently defies rules (oppositional)				
15. Hyperactivity				
16. Abnormal eating habits				
17. Preoccupation with fire, gore or evil				
18. Persistent nonsense questions and incessant chatter				
19. Poor hygiene				
20. Difficulty with novelty and change				
21. Lack of cause-and-effect thinking				
22. Learning disorders				
23. Language disorders				
24. Perceives self as a victim (helpless)				
25. Grandiose sense of self-importance				

Please place a mark in the appropriate column for each symptom as it pertains to your child. On a separate sheet of paper, please give a brief description of your child's behavior regarding each symptom marked as moderate or severe.

	None	Mild	Moderate	Severe
26. Not affectionate on parents' terms	_____	_____	_____	_____
27. Intense displays of anger (rage)	_____	_____	_____	_____
28. Frequently sad, depressed or hopeless	_____	_____	_____	_____
29. Inappropriate emotional responses	_____	_____	_____	_____
30. Marked mood changes	_____	_____	_____	_____
31. Superficially engaging and charming	_____	_____	_____	_____
32. Lack of eye contact or closeness	_____	_____	_____	_____
33. Indiscriminately affectionate with strangers	_____	_____	_____	_____
34. Lack of or unstable peer relationships	_____	_____	_____	_____
35. Cannot tolerate limits and external control	_____	_____	_____	_____
36. Blames others for own mistakes or problems	_____	_____	_____	_____
37. Victimizes other (perpetrator, bully)	_____	_____	_____	_____
38. Victimized by others	_____	_____	_____	_____
39. Lacks trust in others	_____	_____	_____	_____
40. Exploitative, manipulative, controlling, bossy	_____	_____	_____	_____
41. Chronic body tension	_____	_____	_____	_____
42. High pain tolerance	_____	_____	_____	_____
43. Tactily defensive	_____	_____	_____	_____
44. Genetic predispositions	_____	_____	_____	_____
45. Lack of meaning and purpose	_____	_____	_____	_____
46. Lack of faith, compassion and other spiritual values	_____	_____	_____	_____
47. Identification with evil and the dark side of life	_____	_____	_____	_____
48. Lack of remorse or conscience	_____	_____	_____	_____

CONSENT TO TREATMENT

The Independent Practitioners
at the Barn on Sycamore

I, _____ (parent/guardian on behalf of CLIENT), request the professional

counseling services of _____ (hereinafter referred to as THERAPIST).

In requesting these services, CLIENT understands:

- THERAPIST operates his/her practice individually, separate and apart from other mental health professionals sharing office space with him/her
- other mental health professionals have no responsibility or liability for CLIENT'S treatment unless CLIENT requests their services and signs a treatment agreement with them.
- Psychotherapy has both benefits and risks.
- CLIENT may get worse before getting better, however the profit can outweigh the costs.
- Psychotherapy has been proven to have significant benefits both physically and mentally.
- CLIENT is encouraged to ask questions and offer ideas throughout their treatment.

Communication – initial here to acknowledge acceptance of these terms: ☐

- THERAPIST'S preferred method of scheduling will be through an encrypted client portal. Instructions for registering for the portal will be provided to the CLIENT by request.
- Scheduling will occasionally be accommodated by phone. If THERAPIST is not available to receive a call, phone messages will be returned within 12 hours (with the exception of weekends and holidays.)
- Should THERAPIST choose to offer scheduling via text messages or email, messages will be responded to as thus: text messages within 24 hours, and emails within 48 hours. Information shared via text or email should pertain to scheduling only.
- Contact via social media applications is NOT an appropriate means for CLIENT to communicate with THERAPIST, therefore, THERAPIST will NOT respond to any messages, requests or communications initiated in this manner.

Recordings

- Audio and/or video recordings of sessions is strictly prohibited without the advance, written consent of ALL session participants, including the THERAPIST(S) and CLIENT(S).

Emergencies

- THERAPIST listed above is available by appointment only and will make every effort to return CLIENT's call as soon as possible (with the exception of weekends and holidays.)
- If CLIENT is receiving care when THERAPIST is out of town, THERAPIST may, if needed, provide CLEINT the name of a colleague to contact.
- In the case of an emergency and/or when THERAPIST is not available, CLIENT is urged to call 911, contact Avera Behavioral or visit an emergency room at either Avera McKennan or Sanford Hospital.

Confidentiality

In general, the law protects the confidentiality between CLIENT and THERAPIST. However, the following exceptions may occur:

- *CLIENT authorizes the release of information with a signature.*
- *THERAPIST is ordered by the court to release information.*
- *CLIENT presents a physical danger to self or others or has intent to commit a crime.*
- *There is evidence or reasonable suspicion of child/elder abuse and/or neglect.*

Financial Agreement

- Payment is due at the time of service. This may include CLIENT's full fee (if cash payment option has been chosen) or a co-pay associated with CLIENT's insurance company.
- This office will provide necessary information to your insurance company and attempt to collect payment. CLIENT is ultimately responsible for payment of CLIENT's account. Amounts due and billable may include differences between copay paid by CLIENT and what is actually owed according to CLIENT'S insurer, charges incurred and applied toward CLIENT's deductible and coinsurance.
- Copays, deductibles and/or coinsurance are determined by your insurer, not by your THERAPIST. As a network provider with your insurance company, your THERAPIST is contractually bound to collect the amounts due as defined by your carrier.

If you are unsure of you insurance coverage, you can learn more by referring to your policy booklet or by calling the toll-free number listed on your insurance card.

HIPAA Notice of Privacy Practices

This office is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. **Please initial here to acknowledge receipt of this Notice.** _____

In regards to CLIENT's rights, CLIENT as the consumer has the right to fair and professional treatment; all HIPAA regulations apply to this office which CLIENT may request at any time.

CLIENT has been given the opportunity to ask questions which have been answered to their satisfaction. CLIENT has read the above and has had the opportunity to discuss this information and any questions with THERAPIST. CLIENT also confirms that the information they have provided THERAPIST for their treatment is current and accurate.

CLIENT completely understands his/her rights, his/her consent to treatment, and accepts his/her responsibilities as stated above.

CLIENT Signature Date

Completed and Witnessed by Date

Parent/Legal Guardian (if CLIENT is a minor) Date