FAMILY THERAPY INSTITUTE
MIDWEST

Empowering change through collaboration, education, and connection

Child/Adolescent (under 18) Information Form

Client Name First | Middle | Last

Address

City **State** **Zip**

Home ☎ **Office ☎** **Mobile ☎**

Email

[Please DO NOT include phone numbers or email addresses at which you do not want to be reached under any circumstances.]

DOB **Age** **SSN#**

Sex ○ Male ○ Female

Years of Education

Employer or School **Work/ School Status**

Referred By **Emergency Contact* [name & #]**

*Please provide a name and phone number for someone who could be contacted in case of a serious health emergency. By providing this number you are authorizing FTI Midwest to contact this person under these unusual circumstances

Insurance Information

Client's, who qualify by diagnosis, and wish to do so, may choose to have their treatment reimbursed by a medical insurance carrier. You may do this by receiving a bill and forwarding it to your insurance company, or by having us bill the company directly. In either case it is likely to be necessary for us to have some contact with the company to provide information necessary for billing. By signing this form you are agreeing to allow us to provide whatever information is legally allowed to assure reimbursement for services we may render. Typically this will include diagnosis, but some insurance companies ask for treatment plans, and goals and objectives. Insurance companies are bound by Federal laws guiding confidentiality, but FTI Midwest cannot be responsible for any records once they are released to your company. To learn more about your insurance company's policies on these matters, please contact them directly.

PLEASE NOTE: WE DO NOT ACCEPT MEDICARE AS PRIMARY OR SECONDARY INSURANCE. EVEN IF A CLIENT HAS ANOTHER INSURANCE POLICY, IF THEY ALSO HAVE MEDICARE WE CANNOT SEE THEM because we will not be reimbursed and the client cannot pay us directly.

Relationship of client to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Does more than one insurance company cover this client? ☐ Yes* ☐ No

*If "yes" you must complete a second form with insurance information. Please ask the receptionist for this form.

If you are the insurance policyholder, you may put "same" in any box that you have already filled out on page 1. If you are not the policyholder you must complete all of the following information for us to bill the insurance company on behalf of the client.

Policy Holder First | Middle | Last

Address

City **State** **Zip**

Home ☎ **Office ☎** **Other ☎**

[Please do not include phone numbers at which you do not want to be reached under any circumstances.]

DOB **Age** **SSN#**

Marital Status **Sex** ○ Male ○ Female

Employer or School **Work/ School Status**

Insurance Co Name **Ins ID Number** **Group Number**

Insurance Co Address **Insurance Co Phone ☎**

I have read the above statement or had it explained to me and my questions have been answered. I agree to release FTI Midwest to provide all information necessary to my insurance carrier in order to process my claim and, if FTI-Midwest is billing my company directly, have all benefits assigned to FTI-Midwest.

Parent or Legal Guardian Signature Date

Clinical Information

For us to give the best service possible, please answer the following questions.

1. Was this child adopted? No ❒ Yes ❒ (age at adoption: _____)

2. Who does the child live with? Mother ❒ Father ❒ Relative ❒ Foster home ❒ Other ❒: ____

3. Who has legal custody of the child?: _____

4, Who cares for the child during the day?: _____

5. Who disciplines the child at home?: _____

6. Have there been divorces, separations, deaths, or serious illness in the family since the child's birth? No ❒ Yes ❒

7. To the best of your knowledge has this child been **sexually** abused?
No ❒ Yes ❒ Possibly ❒

8. To the best of your knowledge has this child been **physically** abused?
No ❒ Yes ❒ Possibly ❒

9. Has this child ever been removed from the home by social services or law enforcement? No ❒ Yes ❒

10. **School Information**

Name of School: _____ Grade: _____

Teacher: _____ Counselor: _____

11. **Medical Information**

Child's Doctor: _____

Doctor Location: _____

Date of last physical exam or treatment: _____

Is the child being treated for any medical or surgical conditions? No ❒ Yes ❒

Has the child ever had an injury to the head requiring medical treatment? No ❒ Yes ❒

Does the child have allergies or bad reactions to medications or other substances? No ❒ Yes ❒

Please list: _____

Current Medications

Name	Indication	Dose/Frequency	Start Date	Prescriber

12. Counseling and Psychiatric Information

Treatment Dates	Diagnosis	Inpatient	Outpatient	Medications	Clinician/Facility

Does the child get social security disability benefits for a psychiatric condition or have they been applied for? No ❒ Yes ❒

Has the child ever taken tranquilizers, antidepressants, pain or sleeping pills, or similar medications? No ❒ Yes ❒

Please list: _____

Has a teacher or doctor ever suggested that this child might have Attention Deficit Hyperactivity Disorder (ADHD)? No ❒ Yes ❒

13. The child's family:

Parents:	Age	Current Location	Health Status	Mental Health/SA Hx.
Mother				
Father				

Siblings Name(s)	DOB/Age	Living with (Other than parent)	Medical Problems	Mental Health/ Substance Abuse Tx.

Please write below anything else about the child's family that you feel would be useful in treatment:

14. Early Childhood Information

Mother's age at child's birth: _____ Father's age at child's birth: _____

Length of pregnancy: _____ Child's birth weight: _____

Which of the following happened to the mother during the pregnancy?

a. Serious illness ..... No ❒ Yes ❒
b. Spotting blood ..... No ❒ Yes ❒
c. Severe vomiting/nausea ..... No ❒ Yes ❒
d. Frequent alcohol use ..... No ❒ Yes ❒
e. Use of prescription medication ..... No ❒ Yes ❒
f. Use of marijuana ..... No ❒ Yes ❒
g. Use of cocaine, crack or similar drug..... No ❒ Yes ❒
h. Use of other drugs or medications ..... No ❒ Yes ❒
i. Other problems: _____

Which of the following occurred during the birth of this child?

a. Difficult labor ..... No ❒ Yes ❒
b. Born other than head first..... No ❒ Yes ❒
c. Blue or yellow color at birth..... No ❒ Yes ❒
d. Problems breathing ..... No ❒ Yes ❒
e. Rh blood problem ..... No ❒ Yes ❒
f. Other problems: _____

Which of the following occurred when this child was a baby?

a. Difficulty with breast or bottle-feeding..... No ❒ Yes ❒
b. Difficulty eating solid food..... No ❒ Yes ❒
c. Difficulty giving up bottle or pacifier ..... No ❒ Yes ❒
d. Wanted to eat too much or too little ..... No ❒ Yes ❒
e. Had colic ..... No ❒ Yes ❒
f. Failure to thrive ..... No ❒ Yes ❒
g. Other problems: _____

Which of the following occurred before age 5?

a. Stomachaches or vomiting ..... No ❒ Yes ❒
b. Problems in potty training ..... No ❒ Yes ❒
c. Slow sitting up or walking alone ..... No ❒ Yes ❒
d. Slow learning to talk or difficult to understand ..... No ❒ Yes ❒
e. Clumsiness ..... No ❒ Yes ❒
f. Accident prone..... No ❒ Yes ❒
g. Other problems: _____

Checklist of Concerns

15. Check how often these problems have happened to the child **during the last six months?**

	Rarely/Never	Sometimes	Often
Seeing or hearing things that aren't there			
Loss of consciousness/blacking out			
Hearing problems			
Severe headaches			
Big weight loss or gain			
Seizures/convulsions			
Problems going to sleep or staying asleep/nightmares			
Sleep walking/Banging head while sleeping			
Bed wetting/ Soiling or wetting during day			
Is clumsy			
Picks at body Sucks or Chews (Thumb clothing Blanket)			
Shyness or fear of new situations			
Cries easily			
Tells lies or makes up false story			
Breaks or destroys things			
Problems making or keeping friends			
Acts bossy to other kids			
Gets picked on by other kids			
Acts without thinking/does dangerous things/Is excitable			
Has problems learning			
Deliberately hurts animals or people			
Clings to one or both partners			
Worries more than other children			
Seems very sad/sulks or pouts			
Has problems showing or accepting love			
Uses alcohol, marijuana or other illegal drugs			
Has attempted suicide or had suicidal ideas			
Daydreams or stares "into space"			
Takes a long time to start a task			
Lethargic [slow, drowsy, doesn't do much]			
Seems to be confused or in a fog			
Can't remember simple things, [daily routine, etc.]			
Withdrawn, prefers to be alone			
Fidgets or can't stay in seat when asked			
Is easily distracted or loses things			
Can't wait for his/her turn in a game			
Blurts out answers before hearing whole question			
Can't follow instructions well			
Can't keep attention/focus or does not listen			
Goes from one thing to another without finishing			
Has tantrums/Loses temper			
Talks excessively or interrupts or intrudes on others			
Refuses adults requests or rules			
Does things to annoy people			
Is touchy or easily annoyed by others			
Is angry and resentful/tries to get back at others			

Payment Agreement

Obligation. By signing this document, you are agreeing to pay for the services your child receives at FTI Midwest. We pride ourselves on making our services affordable for families and we will work closely with you to keep your account current. However, we also retain a bill collection agency for outstanding accounts that become delinquent. By signing this document you are releasing us to refer your account to collections in the event that you do not make timely payment.

Insurance: If your child has insurance, we will submit claims on your behalf if you authorize us to do so on the insurance form (page 2). However, you must pay all costs insurance does not cover including copayments, coinsurance, deductible and no-show fees (see below). You are responsible for verifying your coverage by calling the number on your insurance card. Some companies REQUIRE YOU TO CALL to get an authorization number before your first session. If you do not make this call, you may end up with a bill that your insurance company will not reimburse. For some diagnoses, some insurance companies require you to pay into your healthcare deductible. You are encouraged to discuss this with your therapist.

EVERYONE MUST READ AND CHECK ONE OF THE FOLLOWING BILLING OPTIONS:

☐ **Self-Pay**: I do not have or do not wish to use my insurance. I am paying all fees in full by cash, check or credit card at time of service. **If you do not always accompany your child to his/her session you must send payment with your child**.

☐ **Health Insurance**: My child is covered by active health insurance. I have contacted my insurance company for authorization (if necessary) and believe they will pay for these services. I agree to pay all costs not covered by insurance including refused claims, deductable, co-pay, no-show fees, or coinsurance. **If you do not always accompany your child to his/her session you must send payment with your child**.

EVERYONE MUST CHECK AND AGREE TO ALL OF THE FOLLOWING:

☐ I understand that all missed appointments and late cancellations incur a charge of $50. A missed appointment is any appointment not cancelled. A late cancel is any appointment not cancelled with 24 hours notice. Fees for missed or late-cancelled appointments due to legitimate emergencies may be waived. I understand that repeated no-shows and/or unpaid no-show fees are grounds for termination of therapy.

☐ I understand that if I do not have my payment at the time of service, my appointment will be cancelled. **If you do not always accompany your child to his/her session you must send payment with your child**.

☐ I understand that I must pay all costs not paid by my insurance carrier. If I have another party (guarantor) paying my bill, I understand that I remain *primarily responsible*. This means that if that person does not pay outstanding charges, I remain liable for them. I also understand that I am subject to collection action if my child's account becomes past due. By signing this document I am releasing FTI Midwest to provide necessary information to it's designated collection agency. I also understand that if I move or relocate without making arrangements with FTI for future billing, I am subject to immediate collection action. I also understand that if my check is returned, a $30 fee will be added to my account.

DIVORCED PARENTS MUST READ AND CHECK THE FOLLOWING:

☐ I am a divorced parent who is not fully responsible for paying medical and mental health care bills of my child. By signing this document I am agreeing to pay all charges incurred as described above regardless of designations made by any court for division of medical expenses. As the presenting parent I understand that I cannot receive services for my child at FTI Midwest if I do not keep my child's account current, regardless of the other parent's attention to the account.

I have read, understood, and agree to the terms regarding consent to treatment and payment for services. I have also reviewed and understand the FTI Midwest's Privacy Policy.

Parent or Legal Guardian _____ Date _____

FTI Witness _____ Date _____