KaraLee & Associates
centre for self and family

NEW PATIENT INFORMATION: Ages under 18

Patient Last Name: Patient First Name: Patient Middle Name:

DOB: SSN:

Gender Assigned at Birth: M [ ] F [ ] Gender Identity:

Address: City: Zip:

Home Phone: Cell Phone: Email:

EMERGENCY CONTACT INFORMATION

First & Last Name: Relationship: Phone:

INSURANCE INFORMATION

Primary Insurance: Policy #: Group #:

Subscriber Name: Subscriber DOB: Relationship:

SSN: Employer:

Secondary Insurance: Policy #: Group #:

Subscriber Name:

Subscriber Date of Birth: Relationship:

Social Security Number: Employer:

I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT & I CONSENT TO TREATMENT.

Parent / Guardian Signature Date

ATTENDANCE AND FINANCIAL POLICIES

Thank you for choosing KaraLee & Associates, P.C. as your mental health care provider. Please understand that payment of services rendered is considered part of your treatment and is expected at each session.

KaraLee & Associates, P.C. providers accept most insurance carriers, but each patient may be responsible for an annual deductible or co-payment, depending on their insurance provider. It is the patient's responsibility to keep track of their appointments and to keep their financial accounts current including copays, deductibles, and service fees.

By initialing each paragraph below, you are stating that you understand our attendance and financial policies.

_____(initial here) I agree to notify my clinician when canceling an appointment at least 24 hours in advance.

_____(initial here) I understand that if I miss my initial appointment, I will incur a $140.00 fee and services will be terminated.

_____(initial here) I understand that KaraLee & Associates, P.C. has the right to charge me $140.00 for missed appointments and cancellations with less than a 24-hour notification. Missed appointments or cancellations fees cannot be billed to my insurance company.

_____(initial here) I agree that if for any reason a check is returned on my account, I will be responsible for a $35 returned check fee in addition to the original fee(s) for service(s).

_____(initial here) I agree to notify KaraLee & Associates, P.C. of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

_____(initial here) I understand that if my balance remains unpaid for more than 90 days and/or exceeds $200, KaraLee & Associates, P.C. may refer my account to a collection agency, and future services may be withheld.

_____(initial here) I understand that I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility. Detailed fees for service are listed on the following page.

_____(initial here) I acknowledge that I have the right to receive a "Good Faith Estimate" if I am not using insurance to pay for my service.

ATTENDANCE AND FINANCIAL POLICIES (CONTINUED)

Potential Fees Incurred by Patient	Fee Associated
Records Request (legal, insurance or personal use)	Base Fee: $30.60 plus: Pages 1-20: $1.53 per page Pages 21-50: $0.77 per page Pages 51+: $0.31 per page
Records Request (continuation of care, records faxed to another medical office only)	Free of Charge
Paperwork/Forms to be Completed by Clinician or Psychiatrist short/long-term disability FMLA worker's compensation disability probation letters for school, lawyers, etc.	Fee determined by time needed to complete: 15 minutes: $62.50 30 minutes: $125.00 45 minutes: $187.50 60 minutes: $250.00
Cancellation of Appointment with Clinician or Psychiatrist (less than 24-hour notice given)	$140.00
Private Pay Clients (no insurance or insurance not used)	Clinicians - Initial Appointment: $210.00 Clinicians - Subsequent Appointments: $140.00 Psychiatrist - Initial Appointment: $250.00 Psychiatrist - Medication Reviews: $85.00

PARENT/GUARDIAN SIGNATURE **DATE**

ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE

Patient Name: _____ DOB: _____

Insurance: _____ ID#_____

I, _____ agree to arrange a payment plan with my provider
(print name here)
to continue services in the event that my insurance coverage lapses or does not cover services rendered. I understand that an Advanced Beneficiary Notice Form (below) must be filled out before continuing services.

REASON FOR ADVANCED BENEFICIARY NOTICE
(Patient/Guardian is responsible for any or all of the following reasons)

1. Maximum visits per insurance contract have been reached.
2. Client is insured by straight Medicaid.
3. Deductible, copay, and coinsurance are not eligible for secondary insurance payment.
4. No-show or Late Cancel with therapist/psychiatrist/nurse practitioner.

Amount of Payment Responsibility

Doctor/Nurse Practitioner Evaluation = $250; Medication Review = $85; Clinician Initial Session =$210; Clinician Subsequent Sessions = $140; No-Show / Late Cancel = $140

I agree that I am the responsible party and KaraLee & Associates, P.C. may ask for payment at the time services are rendered. By signing below, I understand that in the event that my insurance does not pay for mental health services, I agree to pay the amount due for services.

_____

PARENT/GUARDIAN SIGNATURE **DATE**

CREDIT CARD AUTHORIZATION REQUIRED FOR ALL CLIENTS

CREDIT CARD AUTHORIZATION

By signing this form, you are authorizing charges to your credit card by KaraLee & Associates, P.C. for services rendered.

I understand this authorization will remain in effect until I cancel it in writing and I agree to notify KaraLee & Associates, P.C. in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Credit Card Number:	
Credit Card Expiration:	
Credit Card Security Code: (usually, 3 digits located on the back of your card)	

I authorize KaraLee & Associates, P.C. to charge my credit card.

PARENT/GUARDIAN SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request.

PARENT/GUARDIAN SIGNATURE **DATE**

CONSENT FOR TREATMENT

I hereby consent to receive treatment for therapeutic/psychological services through KaraLee & Associates, PC.

PARENT/GUARDIAN SIGNATURE **DATE**

COMPLIANCE WITH CLINIC REQUIREMENTS

I hereby acknowledge an understanding of KaraLee and Associates, P.C. requirements. It is required to engage in ongoing therapy in order to maintain appointments with the psychiatrist/nurse practitioner.

PARENT/GUARDIAN SIGNATURE **DATE**

UNDERSTANDING OF LEGAL PARTICIPATION

I hereby acknowledge the legal participation limits of KaraLee and Associates, PC. Therapists and Psychiatrists do not participate in custody proceedings, custody assessments, or court hearings.

PARENT/GUARDIAN SIGNATURE **DATE**

INFORMED CONSENT FOR TELEHEALTH

Telehealth services are used when mental health staff are not physically present to evaluate your mental health needs and, if appropriate, prescribe medications. Mental Health staff may be present at another location and available to serve you through available technology.

I understand:

1. The potential risk of telehealth services is that there could be a partial or complete failure of equipment being used which could result in telehealth staff's inability to complete the evaluation, mental health services, and/or prescription process.

2. There is no permanent video or voice recording kept of the telehealth service's session.

3. All existing confidentiality protections apply.

4. All existing laws regarding client's access to mental health information and copies of mental health records apply.

5. I have the right to withdraw consent to telehealth services at any time by submitting a revocation of consent in writing.

I understand that I must be in a private location during all telehealth sessions.

PARENT/GUARDIAN SIGNATURE **DATE**

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN
NOT A REQUEST FOR RECORDS

Patient Name: DOB:

Authorize [ ] Do Not Authorize [ ]

The release of any information to my physician by KaraLee & Associates, PC and…

Physician Name: Phone #: Fax #:

Address: City: State: Zip:

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee & Associates, P.C., and my physician. This release expires upon termination of my treatment with KaraLee & Associates, P.C., or upon my written request.

Parent/Guardian Signature **Date**

PERSONAL HISTORY

Presenting Symptoms

- ☐ Anger
- ☐ Anxiety
- ☐ Appetite change
- ☐ Decreased concentration
- ☐ Excessive worry
- ☐ Feeling hopeless
- ☐ Homicidal Ideations
- ☐ Hyperactivity
- ☐ Irritability
- ☐ Mood swings
- ☐ Paranoia
- ☐ Racing thoughts
- ☐ Sleep problems
- ☐ Suicidal Feelings

Presenting Concerns

- ☐ Academic Issues
- ☐ Behavior Issues
- ☐ Health Issues
- ☐ Legal Issues
- ☐ Relationship Issues
- ☐ Sexual Issues

Why has child/adolescent come into treatment?

What would the child/adolescent like to accomplish by coming to KaraLee & Associates, PC?

SUICIDE & SELF-HARM

(circle or check yes or no)

Have they ever thought about suicide or harming themselves? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they have a history of suicide attempts or self-harm? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they currently feel suicidal? (If yes, please explain in the space provided below…)	**yes** ☐	**no** ☐

Explain:

HOMICIDAL ISSUES

(circle or check yes or no)

Have they ever thought about killing or harming others? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they have a history of committing murder or harming others? (If yes, describe when and how in the space provided below…)	**yes** ☐	**no** ☐
Do they currently feel homicidal? (If yes, please explain in the space provided below…)	**yes** ☐	**no** ☐

Explain:

TRAUMA HISTORY

Have they experienced any of the following…

(If answered yes to any, please explain in the space provided below…) (circle or check yes or no)

emotional abuse		**yes**	**no**	
physical abuse		**yes**	**no**	
sexual abuse		**yes**	**no**	
emotional neglect		**yes**	**no**	
physical neglect		**yes**	**no**	
physical assault		**yes**	**no**	
sexual assault		**yes**	**no**	
crime-related events		**yes**	**no**	
general disaster		**yes**	**no**	

Explain:

SCHOOL ADJUSTMENT

School District:

School Name:

Present Grade:

Have they ever been afraid to go to school? [ ] Yes [ ] No

Explain:

Have they repeated any grades? [ ] Yes [ ] No

If yes, what grade?

Have they ever had problems with the following:

Math [ ] Reading [ ] Language [ ] Speech

Explain:

What is the highest math class they successfully passed and what grade did they earn?

Have they ever had special education services? [ ] Yes [ ] No
Explain:

Have they ever received complaints from the school regarding behavior or achievement? [ ] Yes [ ] No
Explain:

SOCIAL INFORMATION

Social time is usually spent: [ ] Alone [ ] With family [ ] With friends

Do they isolate him/herself from other people? [ ] Yes [ ] No
Explain:

Do they have a job? [ ] Yes [ ] No

If yes, how many hours a week do they work?

Position and Type of Work:

ADJUSTMENT DIFFICULTIES

Please check any of the following that are typical (or historical) of the child's behavior.

	feels lonely		overactive		defiant		will not admit blame		ritualistic behavior
	shy with children		lacks motivation		daydreams		short attention span		talks impulsively
	shy with adults		sexual acting out		aggressive with peers		bewetting-present		unusual behavior
	worries		poorly organized		aggressive with siblings		bedwetting-past		unusual thinking
	moody		tics and twitches		aggressive with adults		soils self		violent behavior
	sad		feelings of guilt		jealousy		not always truthful		exploitation
	cries easily		clumsy		fails to understand consequences		prefers to be alone		
	expects failure		sets fires		stealing from home		preoccupied with sex		
	does not share		destructive		stealing from peers		compulsive behavior		

BIRTH & DEVELOPMENT

Normal Pregnancy? ☐ Yes ☐ No Complications? ☐ Yes ☐ No

Length of Labor:

Premature? ☐ Yes ☐ No Weeks/Weight: Newborn's Health:

Please check all that apply…

☐	Colic	☐	Overactive	☐	Constipation
☐	Eating Issues	☐	Underactive	☐	Chronic Illness
☐	Sleeping Issues	☐	Infections	☐	High fevers
☐	Milk or food allergies	☐	Fussy	☐	Hospitalization

EARLY CHILDHOOD

Indicate age started…

Single words: _____ months Sentences: _____ months

Walking: _____ months Began Toilet Training: _____ months

Ending Toilet Training: _____ months Knew colors: _____ months

CURRENT GENERAL HEALTH STATUS

Name of Physician:

Phone Number:

Are their immunizations up to date? [ ] Yes [ ] No

Did they ever have an eye exam? [ ] Yes [ ] No

Do they wear glasses? [ ] Yes [ ] No

Did they ever have a hearing exam? [ ] Yes [ ] No

Do they have a hearing deficiency? [ ] Yes [ ] No

Date of last physical exam:

Results of Last Physical Exam:

What is their present health?

[ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor [ ] Very Poor

Explain:

NUTRITIONAL SCREENING

Have they gained weight in the last 30-60 days? [ ] Yes [ ] No

If yes, how many pounds?

Have they lost weight in the last 30-60 days? [ ] Yes [ ] No

If yes, how many pounds?

Do they have any diet or nutritional concerns? [ ] Yes [ ] No

If yes, explain:

MEDICATION LOG

List prescribed or over-the-counter medication(s) or herbal supplements your child **currently** takes.

Medication	Dosage	Frequency	Prescriber

Allergies/Side Effects:

FAMILY INFORMATION

Family Member Name	Age	Relationship to Child	Do they live with the child?	Yes	No

RELIGION

What religion does the mother practice?

What religion does the father practice?

Does the family practice one of the parent's religions? [ ] Yes [ ] No

Does the child/adolescent participate in this religion? [ ] Yes [ ] No

How important are the child/adolescent's religious beliefs?

[ ] very important [ ] somewhat important [ ] not important

ETHNIC GROUP (OPTIONAL)

[ ] Caucasian [ ] African American/Black [ ] Native American [ ] Hispanic [ ] Asian-American

[ ] Other:

LEGAL HISTORY

Is the child/adolescent currently facing any pending charges or convictions? [ ] Yes [ ] No
Explain:

Is the child/adolescent currently on probation? [ ] Yes [ ] No
Explain:

Has the child/adolescent been on probation in the past? [ ] Yes [ ] No
Explain:

Has the child/adolescent ever been arrested or spent time in a corrections facility? [ ] Yes [ ] No
Explain:

Is/Has the child/adolescent been a part of a divorce or custody issue? [ ] Yes [ ] No
Explain:

Is the child/adolescent adopted? [ ] Yes [ ] No

If adopted, have they been told? [ ] Yes [ ] No
Explain:

HEALTH QUESTIONNAIRE

Now	Past	Neurological	Now	Past	Disease
		stroke			AIDS/HIV
		ADHD			anemia
		headaches			venereal disease
		seizures			mononucleosis
		traumatic brain injury			hepatitis
		sleep disturbance			**Respiratory**
		dizziness			asthma
		fainting			allergies
		tics			bronchitis
		Digestion			pain
		stomach pain			pneumonia
		constipation			**Special Senses**
		diarrhea			hearing disorder
		diabetes			visual disorder
		frequent urination			speech disorder
		bed wetting			**Other**
		overeating			heart disease
		undereating			drug abuse
		vomiting			alcoholism
		nausea			pain disorder
		bleeding			kidney disease
		food allergies			thyroid disorder

If any are checked, please explain:

THERAPY GOALS

Please list what you hope to help your child/adolescent accomplish through therapy.

1.

2.

3.

4.

By signing below, I acknowledge that all legal guardians of the child/adolescent have given consent for treatment. As the parent or legal guardian with authority to consent on behalf of the minor child/adolescent named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment, and/or psychiatric care from the professional staff associated with or employed by KaraLee & Associates, PC. The consent will be valid until the minor reaches the age of 18 but can be revoked at any time by written notification. By all the parties signing below, this will certify that all who have legal custody of the minor have given consent for the mental health treatment of the minor at KaraLee & Associates, PC.

PARENT/GUARDIAN SIGNATURE **DATE**

PARENT/GUARDIAN SIGNATURE **DATE**

CLINICIAN SIGNATURE **DATE**

MEDICAL DIRECTOR SIGNATURE **DATE**