CEDAR CREEK ASSOCIATES LLC

CHILD PATIENT INFORMATION

Date: ______________________________ Clinician/Provider: ____________________

Patient Information

Name: __________________________ Date of Birth: _________________ Age: _____

Local Address: ____

Permanent Address: ____

Is it Ok to contact you via (circle answer): Email: Yes No Email: ____________________ Text: Yes No

Phone: Yes NO Cell: Yes NO Work: Yes NO

Home Phone: ________________ Cell Phone: ___________________ Work Phone: ________________

Sex: _______ Marital Status: _____ Social Security Number: __________________________

Employer: ___________________ Address: ____________________________________

Student: _______ Full Time: _______ Part Time: __________ Not in School: ____________________

Emergency Contact:

Name: _________________________ Relationship: ______________________________

Home Phone: _________ Cell Phone: ______________ Work Phone: ________________________

Primary Physician: _________________ Phone: ___________________________________

- I consent to having my Primary Care Physician notified that I am receiving mental health services.
- I do not consent to having my Primary Care Physician notified that I am receiving mental health services.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________ ______________________________

Name of Patient Date

______________________________ ______________________________

Signature of Responsible Party Name of Responsible Party

The Complete Notice of Privacy Practices is located in our waiting room. It is also on our website Cedarcreekassociates.com under Privacy Act.

CONSENT TO TREATMENT

By signing the document below, you assert that you have read and understand this page, and that you consent to treatment for yourself, your minor child, or your family. I will be happy to discuss any questions or concerns you may have.

CONFIDENTIALITY

What we talk about, and even the fact that you are coming here for treatment, is private information and cannot be disclosed except under the following circumstances:

- If you give me a signed authorization to release the information;
- If I have reason to think you may be an immediate danger to yourself or to others;
- If a court orders me to release the information;
- In order to collect fees, information can be released to the third party payor;
- To other professionals for consultation (in which case your identity will not be disclosed);
- To qualified personnel for management or financial audits (an insurance company audit, for example).

THE NATURE OF PSYCHOTHERAPY

I will use traditional verbal techniques in providing therapy to you, or traditional play therapy techniques with your child. Treatment planning requires an assessment and diagnosis. If you have questions about the diagnosis or the diagnosis process, please ask me.

Some questions that I will ask will be very personal and may cause you more anxiety. Please feel free not to answer, or to talk to me about your feelings about the issue. I may ask you to carry out an assignment outside of the therapy hour. If so, the assignment is intended to help you, but if you feel uncomfortable with it or think it may be harmful in any way, please do not carry it out and do talk with me about your concerns.

I will see you by appointment in my office. If I see you outside the office, I will be friendly, but will not discuss your issues nor indicate the nature of our relationship unless you make it clear that you want the relationship known.

Psychotherapy is not an exact science. It involves a cooperative effort between us. I encourage your questions and open participation. Please discuss with me any questions or concerns about our work, the staff, or the facility. Psychotherapy is intended to address the problems you present and that we agree to work on together. There is a possibility that therapy can make problems worse or even create new problems. Usually, this is a stage toward getting better, but if you do not understand how what we are doing can help, please talk to me about it.

TERMINATION

It is usually most beneficial for therapist and client to discuss the termination process and I encourage you to do so. However, if I have had no contact with you for two months, your case will be automatically terminated. It is always easy to re-open a case, so we can do so if you contact me again.

______________________________	______________________________
Name of Patient	Date
______________________________	______________________________
Signature of Responsible Party	Name of Responsible Party

FINANCIAL POLICIES

Thank you for choosing me as your therapist. Your treatment involves payment for services. Please read this statement of my financial policies carefully, and sign it to show that you have read and understand it.

Fees are charged for the following:

- Therapy sessions (individual, family, couples, or group)
- Non-cancelled appointments or those missed without 48 hour prior notice ($75.00 per incident)
- Preparing/copying records, reports, and letters
- Telephone consultations
- Returned checks
- Interest may be added to accounts due for 90 days
- Court appearances, depositions, travel and preparation time (ask for my legal policy)
- If an account is sent to collection, the fee will be what the collection agency charges plus any legal fees necessary to collect.

Please note:

- Payment is expected at the time of service
- Payment plans are available with prior notice

About Cedar Creek Associates: Cedar Creek Associates is an office-sharing LLC only. It is not a group clinical practice. Each associate maintains his or her own independent practice. No other professional relationship exists among the clinicians.

Regarding Insurance: I may accept assignment of benefits once you provide needed information. This means that you would pay co-pays and deductibles at the time of service and the staff will bill the insurance company for the balance. When we tell you what the benefits and authorizations for sessions are, we cannot guarantee that the information is correct. I am providing you with an estimate of your share of the cost treatment as provided to me by your managed care company, insurance company, or employee assistance program. Sometimes this information is not consistent with later information we receive from the insurance company. Your actual share may be more than this estimate. You are ultimately responsible for the charges. <u>Remember to please let me know if you change insurance or managed care companies</u>.

Managed care companies: Many insurance companies contract with a managed care company to manage the benefits and care. The managed care company may require that I obtain prior authorization for sessions and I usually am required to submit clinical information about you to do so.

By signing below, you authorize me to bill your EAP or Managed Care Company, and you authorize the payer to pay me directly.

Thank you. If you have any questions or concerns about these policies, please speak with me or with one of the office staff.

______________________________	______________________________
Name of Patient	Date
______________________________	______________________________
Signature of Responsible Party	Name of Responsible Party

THE PURPOSE OF THIS RELEASE IS TO ALLOW YOUR THERAPIST TO BILL YOUR INSURANCE COMPANY AND OBTAIN AUTHORIZATION FOR TREATMENT.

Patient's Name (print): ____ Date of Birth: ______________________

1. I authorize the following person: ____ (Name of therapist)

2. To use or disclose the information below from the initial date of service until financial liabilities are satisfied.

____ Inpatient or outpatient treatment records for physical or psychological, psychiatric, or emotional illness.

____ Admission and discharge summaries.

____ Psychological, psychiatric, and or medical evaluations, reports, histories, assessments, treatment notes, treatment plans, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or documents received from other medical and mental health providers.

____ Billing records.

3. Name of your insurance company and/or Employee Assistance Program: ____

4. I understand and agree that this authorization will be valid and in effect until service with this provider is completed and payment of benefits have been collected. I understand that after this date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.

5. I understand that I can revoke or cancel this authorization at any time by sending a letter to my provider. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that time.

6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Provider named above, nor will it affect my eligibility for benefits. However, I may not be able to have further sessions authorized other than those contained in the initial authorization of services and I will assume financial responsibility for all subsequent services.

7. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.

8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

9. I have discussed the issues above with the Provider and I understand the terms of this authorization.

____ ______________________________

Signature of client or his/her personal representative Date

____ ______________________________

Print name above Relationship to client

____

Description of the personal representative's authority

CEDAR CREEK ASSOCIATES
Private, Independent Practitioners

CHILD QUESTIONNAIRE

PERSONAL INFORMATION:

Name: ______________________________ Date: ______________

Date of Birth: ______________________________ Age: ______________

Please list any person living in the child's home:

Name	Age	Relationship	Quality of Relationship

Please list other immediate family members not currently living in the child's home:

Name	Age	Relationship	Quality of Relationship

Mother's occupation: ______________ Father's occupation: ______________

Approximate family income: ______________ Family's religion: ______________

If the child was adopted, at what age? ______________

Does the child know he/she was adopted? ______________

Age when told about the adoption? ______________

Has the child had any contact with the biological parents since the adoption?______________

Does the child mention the biological parents? ______________

EDUCATIONAL INFORMATION:

School:______________ Grade:______________

Does the child seem to like his or her teacher? ______________

Has the child ever failed a

____

grade or been held back? If so, please explain:______________

Has the child ever received special education, special resource, or speech services? Explain:______________

Name: ____________________________

MEDICAL INFORMATION:

Physician: ______________________________ Date of last physical exam: ______________________

Please list any illnesses or medical conditions: ____

List any medication to which the child is allergic: ____

Please list any medications the child takes:

Medication	Amount of Dose	Frequency	Purpose of Medication

Please check and explain any concerns or events from the list below:

- ____ The child's weight or diet: ____
- ____ Has the child ever been unconscious from a head injury? ______________________________
- ____ Has the child ever been neglected, traumatized, or abused? __________________________
- ____ Has the child had previous counseling or testing? ______________________________
- ____ Has the child ever been hospitalized? ______________________________
- ____ Has the child tried or used drugs, tobacco, or alcohol? ______________________________
- ____ Does the child drink caffeine (soda, tea, coffee) and how much? ______________________________

Has any person in the child's biological family ever:

- ____ Had depression?
- ____ Had schizophrenia?
- ____ Committed suicide?
- ____ Had an anxiety disorder?
- ____ Been hospitalized for a psychiatric illness?
- ____ Had a problem with alcohol or drug abuse?
- ____ Had bipolar or manic-depressive disorder?
- ____ Been imprisoned for a felony?
- ____ Had a learning disability or ADHD?

Has the child ever been the victim of a crime? If so, please explain:

____

SOCIAL/RECREATIONAL INFORMATION:

Please list the child's hobbies and interests: ____

How well does the child get along with peers? ____

Does the child have a best friend? ______________

Estimate the number of hours per week the child watches TV: ______________________________

Does the child have a TV in the bedroom? ________

Estimate the number of hours per week the child plays video or computer games: ______________________

Does the child have access to the internet? _________ Do you restrict access to the internet, games and/or movies with violent or sexual content? ____

Name: ____________________________

PRESENTING PROBLEM:

Please explain why you are seeking treatment for your child:____

____

How severe are these concerns to you? _____ Mild _____ Severe _____ Extremely severe

How severe are these concerns to the child: _____ Mild _____ Severe _____ Extremely severe

When did the problem(s) begin?____

What have you done to try and solve the problems? ____

Please check any symptoms your child is having:

_____	Tiredness	_____	Difficulty sleeping	_____	Increased tears
_____	Argues a lot	_____	Loss of interest in activities	_____	Nervousness
_____	Irritability	_____	Withdrawal from others	_____	Clinging
_____	Worries a lot	_____	Changed eating habits	_____	Destructive
_____	Refuses to go to school	_____	Hurts self or talks about it	_____	Poor attention
_____	Aggressive behavior	_____	Hurts others or talks about it	_____	Nightmares
_____	Soils or wets self	_____	Grades have dropped	_____	Over sleeps
_____	Rude to parents	_____	Won't follow instructions	_____	Disobedient

Strange ideas:____

Other: ____

Please check any recent changes the child has experience:

_____	Illness or injury	_____	Family moved	____	Friend moved
_____	Sibling left home	_____	New family member	-	Parent left home
_____	Loved one died	_____	Experienced or witnessed violence		Parents divorced
_____	Child moved into/away from family				

Other major loss or event: ____

Other:____

Name: ______________________________

I give permission to ____________________________ to treat my child ____________________________________ in psychotherapy. I am the custodial parent or legal guardian of the child and I have the legal authority to authorize Treatment. I understand that I am financially responsible for fees incurred in this treatment.

_______ Without the consent of anyone else.

_______ Only with the consent of:

____
Name

____
Address (number and street)

____
City, State and Zip Code

____
Phone Number

_______ I agree to provide any necessary documentation.

I understand that no child custody evaluation will be performed and that therefore my therapist will not formulate an opinion regarding any custody issues, and that requiring the therapist to testify regarding custody issues would be harmful to my child and the therapeutic relationship.

Printed name of parent or guardian	Relationship to child
Signature of parent or guardian	Date

Thank you for selecting me as your child's therapist. Please feel free to discuss any concerns you may have about your child's treatment. At any time that I am alone with your child, you are invited to open the door and check on your child's well-being. The ending of therapy is as important to children as what takes place within it and I request that you talk with me about how therapy will terminate before we actually end.

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure-Child Age6-17

Child's Name: ______________________________________ **Age:** ___ **Sex:** ☐ **Male** D **Female** **Date:**_____________

Relationship with the child:______________________________________

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered **by** each problem during the **past TWO(2) WEEKS.**

		During the past **TWO(2) WEEKS,** how much (or how often) hasyour child ...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping-that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V.&	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices-when there was no one there-speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake-that is, sawsomething or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No		☐ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No		☐ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No		☐ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No		☐ Don't Know		
XII.	24.	In the past **TWO(2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No		☐ Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No		☐ Don't Know		