CEDAR CREEK ASSOCIATES LLC

PARENT OF ADOLESCENT PATIENT INFORMATION

Parents, please complete pages 1 - 10. Adolescents, please complete pages 10 - 12

Date: ______________________________ Clinician/Provider: __________________

Name of Patient: _________________________ Date of Birth: ________________

Parent Information

Name of Parent Completing the form: _________________________ Date of Birth: ________________

Permanent Address of Patient ____

Parent's 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: _____

Employer: __________________ Address: ___________________________________

Student: _______ Full Time: _____ Part Time: ________ Not in School: _________________

Emergency Contact:

Name: ________________________ Relationship to Adolescent_______________________

Home Phone: __________ Cell Phone: ___________ Work Phone: ____________________

Family Physician: _________________ Phone: __________________________________

- ☐ **I consent to having my Primary Care Physician notified that I am receiving mental health services.**
- ☐ **I do not consent to havng 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. **The Complete Notice of Privacy Practices is located in our waiting room. It is also on our website Cedarcreekassociates.com under Privacy Act.**

______________________________ ______________________________

Name of Patient Date

______________________________ ______________________________

Signature of Responsible Party /Parent Name of Responsible Party/Parent

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);
- If a report of child or elder abuse is suspected.

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.

To keep our focus on the therapy process, I will not communicate with you on social media during or after our work together.

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 /Parent	Name of Responsible Party/Parent

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. Remember to please let me know if you change insurance or managed care companies.

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/ Parent ______________________ Name of Responsible Party/Parent ______________________

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 understand that Teletherapy may be utilized as approved by my carrier.

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

______________________ ______________________
Signature of client or Responsible Party/Parent Date

Print name above Relationship to client

____
Description of the personal representative's authority

PERMISSION TO TREAT

I give my permission to ____ to treat my child,

______________________________, date of birth ______________________, in

outpatient psychotherapy. I am the custodial parent or guardian of this child and have authority to authorize non-emergency treatment.

I understand that I am financially responsible for fees incurred in this treatment.

Approximate family income: ________________ Family's Religion: ______________________________

If the child was adopted, at what age? _____

Does the child mention the biological parents? ____

Does the child know (he/she was adopted? ____________ If yes, at what age?________
Has the child has any contact with biological parents since the Adoption? ________________________

I will provide a copy of the court document that defines the custody/conservatorship of my role with this child.

....

Printed name of parent or guardian *Relationship to child*

....

Signature of parent or guardian *Date*

NOTE TO PARENT OR GUARDIAN

Thank you for selecting me as your child's therapist. Please feel free to discuss with me 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 during the therapy. Therefore, I request that you and I spend time talking about how we will stop the therapy before we actually end it.

Thanks again.

CEDAR CREEK ASSOCIATES

PARENT OF ADOLESCENT QUESTIONNAIRE

Name of Patient: .... Date ....

Presenting Problem

Please state the reason you are seeking treatment for your child ______________________________

____

How severe is/are the problem(s) to you?

1 2 3 4 5

Mildly upsetting Severe Totally incapacitating

How severe is/are the problem(s) to your child?

1 2 3 4 5

Mildly upsetting Severe Totally incapacitating

When did the problem(s) begin? ______________________________

What have you or your child tried to do to solve the problem? ______________________________

....

Which areas in your child's life do these problems affect?

School performance	____	Self esteem	____	Friendships	____
Family relationships	____	Daily activities	____	School activities	____

Other ______________________________

Please check any issues your child is experiencing:

Tiredness	____	Difficulty sleeping	____	Crying	____
Argues a lot	____	Sadness	____	Nervousness	____
Loss of interest in activities	____	Changed eating habits	____	Mood swings	____
Withdrawal from others	____	Irritability	____	Depression	____
Misses school	____	Overly active	____	Destructive	____
Hurts self or talks about it	____	Sleeps too much	____	Too aggressive	____
Too passive	____	Worries a lot	____	Nightmares	____
Grades dropped	____	Won't cooperate	____	Strange ideas	____
Won't obey	____	Suicide attempt	____		

Please check any recent changes your child has experienced:

New school or new grade of school	____	Illness, injury, or recovery	____
Child moved into or away from home	____	Family moved	____
Parents separated or divorced	____	Sibling left home	____

Name : ______

Loved one died ___ Grades changed ___

New family member ___ Legal trouble ___

School trouble ___ Any violence ___

Other major loss ___ Other ___

Personal and Family Information

Mother's occupation ___ Father's occupation ___

Were the birth parents married: ___ Yes ___ No Are the parents divorced: ___ Yes ___ No

Age of child at time of the divorce: ___ Year of the divorce: ___

Step-Mother's occupation ___ Step-Father's occupation ___

Approximate Family Income ___ Religion: ___

List all people living in the home:

Name	Age	Relationship	Quality of Relationship

List other immediate family members not living in the child's home that have a role in the adolescent's life:

Name	Age	Relationship

How would you characterize the step-parent's relationship with the adolescent?

___ Excellent ___ Good ___ Average ___ Poor ___ Bad

Educational Information

School ___ Grade ___

Has your child ever failed a grade or been held back: ___ Yes ___ No

What kinds of grades does the child earn? ___

Has your child ever received special education programming?: ___ Yes ___ No

Health Information

Date of last physical exam ___ Physician ___

Please list any illness or medical conditions ___

Please list all medications and state the purpose for each ___

Please list allergies (include allergies to medicine) ___

Do you (or does your child) have any concern about the child's weight or diet? ___ Yes ___ No

Has your child ever been unconscious from a head injury? ___ Yes ___ No

Name : ______

Has your child ever been abused sexually or physically, neglected, the victim of a crime, or otherwise traumatized?

___ Yes ___ No Were charges filed? ___ Yes ___ No

To your knowledge, does your child use (or has he/she tried):

Alcohol	___	Barbiturates	___	Cocaine	___
Crack	___	Heroin	___	Inhalants	___
LSD	___	Marijuana	___	Opiates	___
PCP	___	Other	______		

Has any other member of the family had a drug or alcohol problem now or in the past? ___ Yes ___ No

If so, please indicate who, the substance used, and whether the problem is ongoing:

Has any member of the child's immediate or extended biological family ever had a nervous or mental disorder? ______ If so, please state the person's relationship to the child and the nature of the problem

Has your child ever received counseling before or had an evaluation? ______ If so, please name the provider and give dates ______

Social and Recreational Information

Please list your child's hobbies and interests: ______

Does your child have friend his or her age? ______ Does your child have a best friend? ______

How would your describe your child's relationships with peers? ______

Does he or she have a girl/boyfriend? ______

Which of your child's activities do you and/or your spouse regularly attend? ______

Please describe any past or present legal problems or situations that involved your child:

______

Multimedia Information

Do you have concerns about your adolescent use of devices ___ Yes ___ No

(i.e., Computer, tablets, gaming consoles or smart phones)

About how many hours a day does your child spend on a device? ______

Does your child get your permission before watching a movie? ___ Yes ___ No

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________ **Age:** ____ **Sex:** ☐ Male ☐ 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) has your 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, saw something 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			

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.

CEDAR CREEK ASSOCIATES LLC

Adolescent Patient Information

Date: ______________________ Clinician/Provider: ______________________

Adolescent Information

Name: ______________________ Date of Birth: ______________ Age: ____

Permanent Address: ____

Sex: ______

Employed: ______ No ______ Yes ______ Employer:

Student: ______ Full Time: ______ Part Time: ______ Not in School: ______

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

I acknowledge that suspected abuse of a child or elderly adult needs to be reported to the appropriate authority for investigation.

______________________ ______________________

Adolescent Signature Date

______________________ ______________________

Signature of Responsible Party /Parent Name of Responsible Party/Parent