Wise Mind Psychological Services P.L.L.C.

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Phone: 516-740-1950

Child/Adolescent Registration Form

EVERYTHING MUST BE FILLED OUT COMPLETELY-PLEASE PRINT CLEARLY.

_____ _____ _____
Child's Name (Last name, First name) Date of Birth Age

Address: _____

City: _____State:_____ Zip: _____

Social Security #:_____

Telephone Numbers: (H) _____ (C) _____ (Wk) _____

Name of Father: _____Contact Information: _____

Name of Mother: _____ Contact Information: _____

Who is completing this form? _____

Appointment with: _____ Referred by: _____

Emergency Contact:
Name: _____ Phone: _____

Relationship: _____

Primary Care Physician's:
Name: _____ Phone: _____

Child's School Grade: _____ School Name & Location: _____

Phone number: _____ Teacher's Name: _____

If currently prescribed medication, Psychiatrist's or Prescribing Physician's:
Name: _____ Phone: _____

If applicable, Case worker, CPS worker, Previous Therapist, Probation officer, or Legal aid's:

Name: _____ Phone: _____ Title: _____
Name: _____ Phone: _____ Title: _____

Name: _____ Phone: _____ Title: _____
Name: _____ Phone: _____ Title: _____

Reason for Services at this time:

_____
_____
_____
_____

Has the child experienced any of the following recently:
____ illness ____ trauma ____ death of significant person
____stress ____accident ____relocation ____separation from significant person

If so please explain:

_____
_____
_____

A. PREGNANCY HISTORY
Describe the mother's condition during the pregnancy, her health, diet, and state of mind. How much caffeine was used (coffee,Tea, cola)? Alcohol? Tobacco? Marijuana? Other Drugs Prescription Medication? Was a doctor seen regularly?

Please check any of the following that were present during the pregnancy:

___Accident	___Anemia	___Frequent bleeding	___Low blood pressure
___Diabetes	___Infection	___Transfusion given	___High blood Pressure
___Anxiety	___Surgery	___Rh incompatibility	___Family problems
___Depression	___HIV	___Stomach problems	___Other: _____

How many births before this child? ____How many miscarriages? ____ Age of mother at child's birth? ___

Before the pregnancy, what medication
(prescribed or over the counter) did the mother take? List them_____
During the pregnancy, what medication
(Prescribed or over the counter) did the mother take? List them _____
Post-pregnancy, what medication
(prescribed or over the counter) did the mother take? List them _____
_____

B. BIRTH HISTORY
Is the child ___ a foster child or ___an-adopted child.
The pregnancy lasted ___weeks: the labor lasted ___hours
The child was born ___on the time / ___weeks early / ___ weeks late.
Labor was ___easy /___ somewhat difficult /___hard /___very difficult. Forceps were used? ___yes ___no The delivery was ___Cesarean I ___Natural I ___local anesthesia / ___ general anesthesia
The delivery was: ___ head first I ___other: (specify)_____

Was anything unusual at birth? Please check all that apply and add more details below:

___Cord around neck ___Baby didn't cry ___Baby needed transfusion ___Blue baby
___Baby was jaundice ___Had Difficulty feeding ___Fetal Alcohol Syndrome ___PKU
___Had trouble breathing ___Needed oxygen ___Had difficulty sucking ___Low placenta
___Baby was unresponsive ___Prolapsed cord ___Needed incubator ___Separated placenta
___Birth Defect Explain:
Give details or note anything else that was unusual:

C. INFANCY and EARLY CHILDHOOD

Child's weight at birth: ___lbs. ___ oz.
Weight when leaving Hospital: ___lbs ___ oz.
Age when first crawled: ___
Age when first word spoken: ___
Age when first sentence spoken: ___
Age when toilet trained: ___
hard.
Child was fed by ___breast /___ formula and was weaned from breast or bottle at age_____
How long was baby in hospital? ___
Age when able to sit up by self: ___
Age when took first steps alone: ___
Age when first phrase was spoken: ___
Child was ___ left/___ right handed at age ___ Toilet training was ___very easy /__easy/__hard/__very
Any vision difficulty? ___No/ ___Yes Have eyes been examined? ___No/ ___Yes, when? _____ Any hearing difficulty? ___No/ ___Yes Have ears been examined? ___No/ ___Yes, when? _____

Please check any of the following difficulties your child may have or has had. Giving details below:

___Walking ___Weak muscles ___Hard to understand verbally ___Irritability
___Running ___Muscle tension ___Shy and inhibited ___Difficulty feeding and digesting
___Falling ___Stiffness ___Difficulty writing ___Fearfulness
___Playing Sports ___Says very little ___Difficulty drawing ___Very clinging
___Speech/ Language delay
Give details or note anything else that was unusual:

D. CHILDHOOD ILLNESS Please check all diseases or conditions that have occurred:

___allergies ___chicken pox ___heart disorder ___meningitis
___anemia ___chronic bronchitis ___jaundice ___mumps
___asthma ___diabetes ___kidney disorder ___pneumonia
___bleeding disorder ___encephalitis ___leukemia ___rheumatic fever
___blood disorder ___enzyme deficiency ___liver disorder ___scarlet fever
___brain disorder ___frequent colds ___lung disorder ___seizures
___broken bones ___frequent ear infections ___Lyme disease ___tuberculosis
___cancer ___frequent stomach upset ___measles ___venereal disease
___cerebral palsy ___genetic disorder ___metabolic disorder ___whooping cough

Explain _____

Child's doctor or clinic: _____ Phone number? _____

If child has any allergies, please list: _____

Psychological services received by child in the past or at present:

Age at time	Length of Treatment	Reason for Treatment	Past	Present

Psychiatric medications that child has taken or is taking now:

Medication & Dosage	When taken Reason for medication	Past	Present

Hospitalizations (or other Medical Services) of child for surgery, illness, or accident:

Age at time	Length of stay	Reason for hospitalization	Location

___Hard to understand verbally ___Shy and inhibited ___Difficulty writing ___Difficulty drawing _____

Children are often affected by the relationship problems or emotional problems of other people in the home. Please indicate whether or not there are such difficulties at home. ___Yes ___No
If so, describe and state your opinion whether this affects your child's behavior or learning problems.

Describe whether the child or any other Family members have been or are being seen for psychotherapy or counseling:

_____
_____

E. HOME LIFE

What is the primary language spoken in the home? _____ Others: _____ Have there been any major family stresses or changes in the past year (e.g. moving with change of school, divorce, significant illness, death of a family member, etc.)?

Do the parents or guardians of this child agree on ways to help the child? ___Yes ___No Please explain:

How is your child disciplined and by whom?

Parents or guardians see a lot more of their child than others do. Often they see good points that only come out at home. What do you think are some of the best things about your child?

F. FAMILY HISTORY

Is there any history of problems among the extended family of the child (mother, father, brother, sister, aunt, uncle, cousin, or grandparent)? Problems such as vision, hearing, speech, or movement: seizures, mental retardation or mental illness: learning disability or other disability. If so, please list them here.

Relationship of
Person to child:_____
_____
_____

Nature of
Problem:_____
_____
_____

G. OTHER HISTORY

Please state which grades were repeated, if any, and describe why:
List any special services your child has received either at school or through an outside agency.

Service	Grade at time	Name of provider
Educational Testing	_____	_____
Reading or Math Help in school	_____	_____
Outside tutoring	_____	_____
Special Class Placement	_____	_____
Occupational Therapy	_____	_____
Psychology Testing	_____	_____
Psychiatric Consultation	_____	_____
Psychological Therapy	_____	_____
Speech & Hearing evaluations	_____	_____
Speech Therapy	_____	_____

H. BEHAVIOR

	Rarely	Now and Then	Sometimes	Often
Plays well with brothers/sisters				
Plays by self				
Plays with friends				
Sleeps poorly				
Has nightmares				
Bites				
Sucks thumb				
Runs away				
Has a bad temper				
Cooperative at home				
Cooperative at school				
Makes friends easily				
Feels afraid				
Is obedient at home				
Is obedient at school				
Pays attention at home				
Pays attention at school				
Does homework by self				
Gets into fights				
Daydreams				
Cries easily				
Wets Bed				
Tells lies				
Becomes to excited				
Takes others' things				
Watches TV				
Helps around the house				
Seems quiet and withdrawn				
Talks about self to family				

Has child had any legal problems? No ____ Yes ____ If yes, briefly describe:

_____

I. REVIEW

Please review the information you have given above. What has been left out? What can add to give a more accurate and more complete picture of your child?

If your best hopes and wishes for your child were to be achieved in the future, how would he or she be different from now?

I certify this information is true and correct to the best of my knowledge. I understand that all information that I communicate will be held in strict confidence. I also understand that New York State also mandates certain limits to confidentiality.

Parent or Guardian's Signature: _____ Date: _____

Insurance Information

Patient Name: _____ DOB: _____

Primary Insurance Co:_____Address:_____

City:_____State:_____Zip:_____Phone:_____

Insurance ID #: _____Policy Holder: _____

Policy Holder's Date of Birth:_____

Policy Holder's Address_____

State: _____ Zip:_____ Phone:_____

Secondary Insurance Co._____Address_____

City:_____ State:_____Zip:_____Phone:_____

Insurance ID#_____Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's Address: _____
_____

State:_____ Zip:_____ Phone:_____

**Please make sure you take care of paying your co-pay at the time of your appointment before leaving the office, if you have one. If we have to bill you there will be an extra $15.00 Administration Fee that you will be responsible for paying too.*

**If you must cancel an appointment please notify your therapist or the office 24 hours in advance. There is a $65.00 fee for a missed/no show appointment or a cancellation with less than a 24 hour notice.*
Our schedules are booked in advance. If for any reason when you get home and check your schedule there is a conflict, please call right away so we can accommodate you. We will try our best to notify you of any schedule changes in advance too.

~Thank you for your cooperation.

Who is responsible for this bill? _____
I certify this information is true and correct to the best of my knowledge. I understand the above statements and I will notify WISE MIND PSYCHOLOGICAL SERVICES P.L.L.C of any changes in my health insurance status. If I do not notify you of any changes and my insurance does not cover any services rendered, I will be ultimately responsible.

Signature:_____ Date:_____

Patient Privacy Policy

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a “Privacy Rule” to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to your personal medical records. You should be aware that we may have indirect treatment relationships with you that include but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment and/or health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use or disclosure of your PHI. The refusal must be made in writing. Under the HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of our Patient Privacy Policy. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have received our privacy notice.

Print Name_____Signature_____Date_____

Patient Rights

Patient Bill of Rights and Responsibilities

I have a right to efficient and effective care individualized to my needs. *My treatment provider will work with me to develop a treatment plan best suited to me. We will use this plan to help us deal with my problems as quickly and effectively as possible.*

I have a right to be treated with dignity and respect. *I will be treated with respect at all times. I will report any misconduct by my treatment provider including social invitations, suggestive remarks, or unwanted touching to WISE MIND PSYCHOLOGICAL SERVICES P.L.L.C and/or the appropriate state agency.*

I may call WISE MIND PSYCHOLOGICAL SERVICES P.L.L.C at any time with questions, comments or complaints.

My treatment provider will make every effort to meet with me at our scheduled appointment time. *If my treatment provider is late, he or she will extend our session, if I am willing, or we will make other arrangements by mutual agreement.*

I have a right to privacy and confidentiality. *All records and communications about me will be treated confidentially in compliance with applicable state and federal laws. These laws may obligate my mental health provider to report suspected abuse or neglect, domestic violence and those who pose a danger to themselves or others.*

Patient Responsibilities

Scheduled appointments are commitments*. I will make every effort to be on time for my appointment(s). If I am late for my appointment, I understand that time will be lost from my session. If I miss an appointment and do not notify my treatment provider at least 24 hours in advance, I understand I will be charged a missed appointment fee.*

I am responsible to pay for services received. *I am aware my insurance plan typically requires me to pay a co-payment (a dollar amount) or co-insurance (a percentage of my treatment provider's fee) at the time services are provided. My insurance plan may also have a deductible (an initial dollar amount) that is my responsibility. Additionally, certain services may be limited and not covered at all by my insurance plan. I understand I am financially responsible for co-payments, co-insurance, deductibles and all services not covered by my insurance plan. My treatment provider, my managed care and my insurance plan's representative will help me determine what services my insurance plan covers.*

My health is my responsibility. *I will contact my treatment provider for any serious situation that arises, even if after normal office hours. I will work with my provider to achieve my treatment goals and will advise my treatment provider of changes in my condition.*

I have read this list of rights and responsibilities or had them read to me. I understand and agree to them. Print

*Name*_____*Signature*_____*Date* _____

CREDIT CARD AUTHORIZATION FORM

Prior to receiving services, our office requests that you provide a credit card to have on file. This information will be used to reserve appointments and ensure payment in the event reimbursement is not made by an insurance company or otherwise. Your appointment time is reserved for you and prevents other clients from using that time. We need at least 24 hours notice, to reschedule or cancel your appointment. You will be charged a fee of $65 for missed appointments, that are not cancelled within this window. Please fill out the information below.

Credit Card Information

Credit Card Type: ____Visa ____ MasterCard ____ Discover ____AmEx

Name as it appears on card: _____

Billing address:

_____

Street Apt/Unit #

_____

City State Zip

Credit Card Number: _____

Expiration Date: _____ CCV: _____

I hereby authorize Wise Mind Psychological Services, PLLC to charge my credit card account for fees related to rendered services. These fees include, but are not limited to, delinquent copays/co-insurances, deductibles, services not covered by my insurance (i.e appointments canceled without 24-hour notice).

This authorization is valid until I provide Wise Mind Psychological Services, PLLC with a written notice of cancellation.

(Client Signature) _____ (Date)_____

(Client Print Name) ____