Associated Psychologists
19900 Ten Mile Road
St. Clair Shores, MI 48080

-FOR OFFICE USE ONLY-

CLINICIAN #_____ ACCOUNT #_____ INSURANCE _____

PLEASE COMPLETE AND SIGN ALL PAGES WHERE INDICATED. ALL INFORMATION MUST BE COMPLETED.

(PLEASE PRINT)

DATE: _____

PATIENT **FIRST NAME_____ M.I.____** ***PATIENT*** **LAST NAME _____ SEX M____ F____**

STREET ADDRESS _____ DATE OF BIRTH _____

CITY, STATE, ZIP CODE _____

***PATIENT SOCIAL SECURITY NUMBER* _____ DRIVER LICENSE# _____**

NAME/PHONE NUMBER OF PERSON TO CONTACT IN CASE OF AN EMERGENCY _____

FOR PATIENTS UNDER 18 YEARS OF AGE:

GUARDIAN NAME _____ GUARDIAN NAME _____

GUARDIAN ADDRESS _____ GUARDIAN ADDRESS _____

CITY, STATE, ZIP CODE _____ CITY, STATE, ZIP CODE _____

GUARDIAN TELEPHONE # _____ GUARDIAN TELEPHONE # _____

***SOCIAL SECURITY * _____ *SOCIAL SECURITY * _____**

***DATE OF BIRTH* _____ *DATE OF BIRTH* _____**

DRIVERS LICENSE#_____ DRIVERS LICENSE# _____

PRIMARY INSURANCE:

INSURANCE COMPANY NAME_____

I.D. NUMBER _____ GROUP NUMBER _____

POLICY HOLDER NAME_____ RELATIONSHIP _____ DATE OF BIRTH _____

EMPLOYER NAME _____

SECONDARY INSURANCE:

INSURANCE COMPANY NAME_____

I.D. NUMBER _____ GROUP NUMBER _____

POLICY HOLDER NAME_____ RELATIONSHIP _____ DATE OF BIRTH _____

EMPLOYER NAME _____

IF THERE ARE INSURANCES IN ADDITION TO THOSE LISTED ABOVE AND IF THERE ARE CHANGES TO THE INSURANCE POLICIES DURING YOUR TREATMENT PLEASE NOTIFTY THE FRONT DESK!!!

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CONSENT TO TREATMENT & DIAGNOSTIC SERVICES

I understand that the services my dependent or I will receive are based on currently accepted practice in the fields of mental health. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

I understand that my records or the records of my dependent are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and federal guidelines, or as allowed by my signature on a release form, with the exceptions written below.

If any service is paid for by an insurance company, either in part or full, I understand that the insurance company or its agents have the right to examine my records at any time. I authorize the examination of my or my dependent's client records by them as they require for reimbursement and verification of services. I also understand that it may be necessary to release information regarding me or my dependent to a Case Manager or insurance verifier from my insurance company in order to process services. I also give my permission to release any information to my insurance company that is required to process insurance claims for services provided my dependent or me.

State of Michigan law requires that certain communicable diseases by reported to the Michigan Department of Health. If it is determined that my dependent or I have such a disease, I consent to disclosure of this to the Michigan Department of Health.

Federal laws and regulations do not protect any information about a crime committed by a client either at a treatment program, or against any person who works for a program, or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

I understand that fees for services are to be paid at the time of the appointment unless other arrangements have been made. If my insurance company does not cover any fees or any portion of fees for the services my dependent or I have received, I accept responsibility for them. If maximum insurance benefits have been reached, I will be responsible for any fees for services subsequently rendered.

I agree to provide information for the development of the treatment plan to be used. **I will keep scheduled appointments. I accept that I am financially responsible for all scheduled appointments and am aware that any appointment that is missed without my giving 24 hours notice may be billed to me because insurance companies will not pay for missed appointments or late cancellations. I understand that I may be billed for these appointments at the usual fee.** If treatment or diagnostic evaluation is terminated by my choice, or because of violation of above rules, I agree to pay all outstanding fees existing at the time of termination.

I understand that it might be necessary to reach me by mail or by telephone during or after my or my dependent's contact for purpose of confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys, and any necessary follow-up.

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DUE TO HIPAA LAWS, IF YOU ARE 18 OR OVER, WE ARE UNABLE TO SPEAK TO ANYONE OTHER THAN YOURSELF REGARDING BILLS OR TREATMENT. IF YOU WANT TO ALLOW US TO SPEAK WITH SOMEONE OTHER THAN YOURSELF PLEASE ASK TO SIGN A RELEASE OF INFORMATION.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services for my dependent or me. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services. I acknowledge that I am aware that the therapist is an independent contractor, self employed, and licensed by the State of Michigan. Further, I have read this Consent and agree with the policies and procedures herein.

_____ _____

Signature of Patient (or Parent/Guardian) Date

PERMISSION AND PREFERRED METHOD OF CONTACT

PLEASE ANSWER EACH QUESTION:

THE OFFICE MAY LEAVE A MESSAGE AT HOME ON MY VOICE MAIL OR WITH ANY INDIVIDUAL ANSWERING MY HOME TELEPHONE ( ) YES ( ) NO

THE OFFICE MAY LEAVE A MESSAGE AT WORK IN MY VOICE MAIL. ( ) YES ( ) NO

THE OFFICE MAY MAIL TEST RESULTS OR OFFICE VISIT FOLLOW UP INFORMATION TO MY HOME ADDRESS OR ADDRESS PROVIDED. ( ) YES ( ) NO

PLEASE GIVE US THE BEST PHONE NUMBER TO CONTACT YOU AT:

_____ _____ _____

(HOME MOBILE WORK) PLEASE CIRCLE ONE **(HOME MOBILE WORK) PLEASE CIRCLE ONE** **(HOME MOBILE WORK) PLEASE CIRLE ONE**

What is your preferred method for us to contact you? (Circle one) HOME WORK MOBILE

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PAYMENT OF FEES

Every day new insurance companies are forming and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover. You should check with your insurance carrier regarding Outpatient Mental Health benefits so you are aware of your coverage regarding office visits, psychological testing, etc. It is to your benefit to be well informed so to prevent having to pay for a service that may have been covered if you had a referral, prior authorization, etc. We will make every effort to verify your benefits with your insurance company. However, this is not a guarantee of payment. Your insurance company needs to view the actual claim with diagnosis and procedure codes before making any payment decisions. If at any time your insurance company believes they paid us in error and requests reimbursement/recovery from this office you will be responsible for all these fees.

- **You are responsible for all co-pays and deductibles. It is against insurance policy to ignore them.**
- **Fees for services are due at the time of service unless other arrangements have been made.**
- **If maximum insurance benefits have been reached, you will be responsible for any fees for services subsequently rendered.**
- **Educational testing, transcription fees and other miscellaneous fees are not covered by your insurance carrier. These services are not billed to any third party carrier (insurance company) and will be your responsibility.**
- **For those insurance companies requiring authorization and you fail to obtain a referral (when required) or prior authorization (when required), you will be responsible for the service rendered.**
- **If you do not inform us of any insurance changes, you will be responsible for the services rendered.**
- **If you do not inform us of all insurance policies, you will be responsible for the services rendered.**
- **If your insurance plan does not cover services that are rendered, you will be responsible for those services**
- **There is a $25 charge for all returned checks (NSF)**

PRIVATE PAY PATIENTS AND/OR THOSE WITHOUT INSURANCE:

- **If you do not have insurance you are responsible for the fees.**
- **Fees for services are due at time of service unless other arrangements have been made.**

I have read and completed the requested information to the best of my knowledge and ability and understand that I am the financially responsible party for the named patient. The signature is that of the person completing this form. For minor children, the individual bringing the child to this office is considered the financially responsible party.

Patient/Guardian Signature **Relationship** **Date**

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IF YOU ARE REQUESTING THAT WE BILL YOUR INSURANCE(S) PLEASE COMPLETE AND SIGN BELOW:

ASSIGNMENT AND RELEASE FOR PRIMARY INSURANCE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. _____ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

ASSIGNMENT AND RELEASE FOR SECONDARY INSURANCE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. _____ ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

_____ _____ _____

SUBSCRIBER/CUSTODIAL PARENT/GUARDIAN RELATIONSHIP DATE

Revised 12/28/2016

Revised 12/28/2016

SOCIAL/MEDICAL QUESTIONNAIRE - CHILDREN/ADOLESCENTS

Patient _____ Date _____

Date of Birth ____/____/____ Age _____ Sex _____

Reason for bringing child at this time? _____

_____

_____

Who referred you to our office? _____

If this is a professional who referred you, do you give consent that we may acknowledge to this person/office that we have seen your child? ____ Yes ____ No

FAMILY HISTORY

Place of Birth _____ No. of Siblings _____ Child's No. In Family _____ Parents' Marital Status Now _____

Father's Name _____ Mother's Name _____

Address _____ Address _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

Stepmother _____ Stepfather _____

Address _____ Address _____

Phone: Home _____ Work _____ Phone: Home _____ Work _____

With whom does the child live? _____

Which parent has legal custody? _____ Mother _____ Father _____ Both _____ Neither

Household members of child's residence:

NAME	AGE	RELATIONSHIP TO CHILD	QUALITY OF RELATIONSHIP WITH CHILD

Child's brothers and sisters who are not in the same home as child:

NAME	AGE	SEX	QUALITY OF THE RELATIONSHIP WITH CHILD

If any brother/sister is deceased, give name and age at death: _____

Is the child adopted? _____ No _____ Yes If "Yes," at what age? _____

Has the child ever lived out of the home? _____ No _____ Yes If "Yes," explain where and why _____

_____

In how many residences has the child lived since birth? _____

What is the child's race? _____ Black _____ White _____Native American _____ Hispanic _____ Asian
_____ Other (specify) _____

What is the child's ethnic background? (e.g. Irish, English, German) _____

What is child's religion? ____ Catholic ____ Protestant ____ Jewish ____ Muslim ____ Hindu
____Atheist ____ Agnostic ____ Other (specify) _____

Child's Father's Education _____ Occupation _____ Age _____ If Deceased, give year _____

Child's Mother's Education _____ Occupation _____ Age _____ If Deceased, give year _____

Is child's father currently employed? ____ Yes ____ No Is child's mother currently employed? ____ Yes ____ No

Does the child's family have financial problems? _____ No _____ Yes

Has the child ever been physically or sexually abused (circle which)? _____ No _____ Yes

Has the child ever physically or sexually abused anyone (circle which)? _____ No _____ Yes

Have the child's parents or any other family members had any mental health or alcohol/other drug problems?

_____ No _____ Yes If "Yes," describe who and what _____

_____

Any other information about the home or family _____

_____

_____

EDUCATION

Child's school _____ Grade _____ Teacher _____

What are child's usual marks? _____ A _____ B _____ C _____ D _____ E

Is child now in a special program? _____ No _____ Yes If "Yes," describe _____

Has child been in a special program? _____ No _____ Yes If "Yes," describe _____

Has the child had any vocational training? _____ No _____Yes If "Yes," describe _____

Has child had any tutoring? _____ No _____ Yes If "Yes," explain _____

Has child been a behavior problem at school? _____ No _____ Yes If "Yes," explain _____

_____

VOCATIONAL

Does the child work? ____ Yes ____ No If "Yes," what job? _____ For how long? _____

SOCIAL RELATIONSHIPS/LEISURE TIME

Does child have? _____Friends _____ Acquaintances _____ Both

How often does child see friends? _____ Daily _____Frequently _____ Infrequently _____ Rarely

How does child spend <u>most</u> leisure time? _____ Alone _____ With Others _____ About Equal

List child's hobbies, leisure time activities, interests and talents: _____

_____

Which does child like best? _____

LEGAL PROBLEMS

Has child been involved with the police/courts? _____ Yes _____ No If "yes," specify the

<u>CHARGE</u>	<u>DATE</u>	<u>OUTCOME</u>	WAS THIS RELATED TO <u>ALCOHOL OR OTHER DRUG USE?</u>

_____

_____

MEDICAL/HEALTH INFORMATION

Describe the child's general physical health: _____ Good _____ Fair _____ Poor
When was child's last physical exam? (month) _____ (year) _____
I can't remember the exact date, but it was approximately _____ years ago.
Reason for last physical exam _____

Name of child's physician _____
Address _____ Phone _____

Pregnancy:

Were there complications? Yes _____ No _____ If "Yes", please explain _____
_____

How long was pregnancy? _____ months How long was active labor? _____ hours

Was baby premature? _____ No _____ Yes If "Yes," how early? _____ months

Type of delivery (check one) _____ Spontaneous _____ Forceps _____ Caesarean

Was baby born (check one)? _____ Head First _____ Feet First (Breech)

Indicate if baby was given: _____ Blood Transfusion _____ X-Ray _____ Electroencephalogram (EEG)

Baby's weight at birth was _____ pounds _____ ounces

Indicate the child's condition in the first two weeks of life. Write the letter "Y" (Yes), "N" (No) or "U" (Unknown):

_____Yellow Appearance _____ Blue Lips _____ Vomiting _____Difficulty Breathing
_____ Feeding Difficulty _____ Irritable _____ High Fever _____Deformed Physically
_____ Slow Responding _____Convulsions/Twitching

Infancy/Childhood/Adolescence:

Was the infant breast fed? No _____ Yes _____ If "Yes," until what age? _____
Did the infant feed well? Yes _____ No _____ If "No, explain _____
Was the infant's weight gain normal? _____ Yes _____ No

Indicate age child: _____ Stood Alone _____Walked Alone _____ Used Words
_____ Spoke Sentences _____ Bladder Trained _____ Bowel Trained
_____ Began puberty/ first menstruation _____

Check all of the following conditions that apply to the child after the first two weeks of life:

____ Vomiting ____ Diarrhea ____Constipation ____ Colic
____ Thyroid Problems ____ Headaches ____ High Fevers ____ Low Blood Sugar
____ Diabetes Mellitus ____ Chest Pains ____ High Blood Pressure ____ Trouble Sleeping
____ Seizures ____ Asthma ____ Attention Problems ____ Nightmares
____ Other(s) (specify) _____

Describe child's sleep generally _____ Good _____ Fair _____ Poor

Does the child have allergies? ____No ____ Yes If "Yes," list them _____
_____

Has child ever had an allergic reaction to a food, medicine, environmental stimulus (e.g. dust, grass) drug or alcohol?
____ No ____ Yes if "Yes," to what? _____

List all serious illness, injuries, accidents and surgeries child has had:

Illness, Injury, Accident, etc.	Child's Age	Hospitalized (Yes or No)	How Long in Hospital?

Any contagious or other diseases? ____ No ____ Yes If "yes," which? _____

Check problems that apply to the child? ____ Speech/Language ____ Hearing ____ Vision
____ Motor Coordination ____ Disability/Handicap

Check those that child eats: ____ Meats ____ Fruits and Vegetables ____ Dairy Products ____ Breads
Describe child's appetite: ____ Good ____ Fair ____ Poor
Does the child eat regularly? ____ Yes ____ No

Has child had all required immunizations (DPT, TOPV, MMR, TD)? ____ Yes ____ No

List any illnesses that run in child's family: _____

EMOTIONAL HEALTH

Has your child had treatment/evaluation of emotional/behavioral, learning or school-related problems?
_____ Yes _____ No

If "Yes," was it:

____ Outpatient ____ Inpatient ____ Day Hospital ____ Substance Abuse
____ Mental Health ____Psychological Testing ____ Psychiatric Evaluation

Name of Center/Individual	Address	Year
1.		
2.		
3.		

Has child ever made a suicide attempt? _____ No ____ Yes If "Yes," in what year(s)? _____

Has child ever had homicidal thoughts or experienced explosive, uncontrolled anger? ___ No ___ Yes If "Yes," describe:

Has the child recently made suicidal/homicidal comments? ____ No ____ Yes If "Yes," explain: _____

Has the child ever engaged in purposeful self-harm (e.g. cutting, burning self, etc.) _____ No ____ Yes
If "Yes," explain: _____

MEDICATION/SUBSTANCE USE

List all medications, alcohol and drugs patient takes or has taken:

Prescriptions	Over-the-Counter	Street Drugs

ANY OTHER INFORMATION YOU WOULD LIKE TO ADD

_____

_____

_____

_____
Signature of Informant Date

_____
Relationship to Patient

I have reviewed this questionnaire with the patient/informant:

_____
Clinician's Signature/Credentials Date