

-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 NOTIFY THE FRONT DESK!!!**

PAGE 1 (CONTINUE TO PAGE 2)

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 be 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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Cheryl Mazzara MD
19900 Ten Mile Road
St. Clair Shores, MI 48081

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

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

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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 most 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

CHARGE

DATE

OUTCOME

WAS THIS RELATED TO ALCOHOL OR OTHER DRUG USE?

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:

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

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

<u>Name of Center/Individual</u>	<u>Address</u>	<u>Year</u>
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