THE PSYCHIATRY & PSYCHOLOGY CENTER
650 GRISWOLD ST., NORTHVILLE, MI 48167
PHONE (248) 912-0080
FAX (248) 912-0208

Child & Adolescent Psychosocial Questionnaire

(Ages 1-17)

In order to better serve you, we would like you to **FULLY** complete this questionnaire and return it to the receptionist as soon as it is complete. Please ensure that no question is left blank. This information is kept strictly **confidential** as required by State and Federal guidelines.

Date: _____

Name: _____

Parent/Guardian Name:_____

Child's D.O.B:_____

Primary Care Physician:_____ Phone:_____

Why have you decided to come into treatment now?

_____

_____

_____

What would you like to accomplish by coming today?

_____

_____

_____

Please indicate whether this child is experiencing any of the following:

( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none

Please explain:_____

Please indicate whether this child has a history of any of the following:

( ) suicidal ideas/expression ( ) homicidal ideas/expression ( ) none

Please explain:_____

_____

_____

In Case of Emergency, Contact:

Name: _____

Relationship: _____

Address: _____

Cell Phone: _____

Residence Situation:
( ) lives with both parents ( ) joint custody arrangement ( ) lives with mother
( ) lives with father ( ) lives with grandparents ( ) other
Family Composition:
Religion (Optional) ( ) Catholic ( ) Protestant ( ) Jewish ( ) Hindu ( ) Other
How important is your child's Religious/Spiritual Beliefs:
( ) very important ( ) somewhat important ( ) not important
Would you like to talk to your therapist about your child's religious/spiritual beliefs? Yes / No
Race (Optional) ( ) Caucasian ( ) African-American ( ) Native American
( ) Hispanic ( ) Asian-American ( ) Other:_____
Would you like to talk to your therapist about any racial/cultural issues? Yes / No
Client's Behavioral Health Treatment History:
Has your child ever seen a behavioral health care provider before? Yes / No
If yes inpatient or outpatient? _____
If yes for Inpatient, Name of Facility: _____
Address: _____
Length of Stay: _____
Number of admissions: _____
If yes for Outpatient, Name of Facility: _____
Address: _____
Name of Therapist: _____ Phone#: _____
What type of therapist were they? ( ) Psychiatrist ( ) Psychologist ( ) Social Worker
( ) Other:_____
When did your child see therapist and for what reason:
_____
_____
Medication History:
What medication do you know your child should not take?_____
What medication do you know your child should not stop taking?_____
What herbal remedies is your child currently taking?_____
Please list all medications this child is **currently** on or has taken in the **last year** (prescription and over-the-counter):
_____
_____
_____
Who has been prescribing the medications listed above?
Name: _____
Address:_____
Telephone No.: _____
Current General Health Status:
Please describe your child's current general health:
( ) Excellent ( ) Very Good ( ) Good ( ) Fair ( ) Poor ( ) Very Poor
Is your child feeling any physical pain at this time? Yes / No
If yes please explain: _____
_____
_____

Nutritional Screening:
Has your child **gained weight** or **lost weight** in the last 30-60 days? Yes / No
If yes, how much and why?
Do you have any diet or nutritional concerns about your child? Yes / No
If yes, please explain:
Does your child have any food or medication allergies? Yes / No
If yes, please list:

_____
_____

Substance Use:
Does your child use Nicotine? Yes / No
If yes, ( ) Cigarettes/Cigars/Pipe ( ) Chewing tobacco
Amount per day:_____ How long have they used?_____
Any related health Problems?_____
Does your child use Alcohol? Yes / No
If yes, How often do they use?_____ How long have they used?_____
How much do they usually drink?_____
Any related health issues?_____
If any Recovery, Longest length of Sobriety:_____
Does your child use any Illegal Drugs? Yes / No
If yes, What drug (s) do they use?_____
How often do they use?_____
How much do they use?_____
When was the last time they used?_____

Developmental History:
Duration of Pregnancy:_____
Smoking during pregnancy Yes / No
If yes, number of cigarettes daily:_____
Alcohol during pregnancy Yes / No
If yes, amount and type:_____
Drugs during pregnancy Yes / No
If yes, please explain:
Medications during pregnancy Yes / No
If yes, please explain:
Complications during pregnancy? Yes / No
What type?:_____

Delivery
Was the labor and delivery of your child normal? Yes / No
If No, Please explain:

_____
_____

Birth Weight _____lbs. _____
Infant days in the Hospital:_____
APGAR (if known)_____

Milestones:
Please indicate and describe if you child has had any problems with **motor skills**, **language**, or **social attachment**: If yes, please specify which area and what happened:

_____
_____
_____

Medical:
Do you feel your child needs a physical exam? Yes / No
When was the last time your child had a physical exam?_____
Has your child suffered from any **childhood illnesses/disorders, operations**, and/or **hospitalizations** (please include dates and ages)
If yes, please explain:
Head Injuries: ( ) without loss of consciousness
( ) with loss of consciousness
Please explain:_____
Convulsions: ( ) without fever ( ) with fever
Please explain:_____
_____

Abuse:
Has your child ever experienced any:
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse ( ) Abandonment/Neglect
If yes, by whom:_____
Length/Duration of abuse:_____
Age of child:
Was it reported to the authorities: Yes / No
Please explain:_____
Has your child ever witnessed abuse:
( ) Physical Abuse ( ) Sexual Abuse
( ) Emotional Abuse Has your child ever inflicted abuse on another person:
Physical abuse: Yes / No
Sexual abuse: Yes / No
Emotional abuse: Yes / No

Family Social History:
Name of child's mother:_____ Age of mother:_____
Level of Education:_____
Name of child's father:_____ Age of father: _____
Level of Education:_____
Biological parents are: ( ) married ( ) separated ( ) divorced ( ) other:_____
How would you describe the relationship between your child and his/her siblings?:
( ) Excellent ( ) Good ( ) Fair ( ) Poor
Please explain:_____

Family History:
Please indicate **any family history** of the following:
( ) Substance Abuse: If yes, indicate who:_____
( ) Mental Illness: If yes, indicate who:_____
( ) Suicide: If yes, indicate who:_____
( ) Autism: If yes, indicate who:_____
( ) Developmental Disability, if yes who:_____
( ) ADHD: if yes, who:_____

Social History:
Please indicate if you have the following concerns regarding your child:
( )Peer Relationships
( )Gang Involvement
( ) Relationship with Authority
( ) Social Support Networks
( )Hobbies/Interest
Please list your child's hobbies and leisure activities: _____
What are the main strengths of your child?
_____
_____

Education:
What grade is your child currently in:
Child Attended:
( ) Infant day care ( ) pre-school ( ) kindergarten
Official School Classifications
( ) LD or ADHD ( ) ED ( ) MR
( ) Visually Impaired ( ) Hearing Impaired ( ) Other
Type of Placement:
( ) regular classes ( ) special education ( ) honors (T&G) ( ) home study
Please indicate if you have any concerns in the following areas:
( ) Adjustments
( ) Behavioral Problems
( ) Repeated grades
( ) Suspensions/Expulsions
( ) Performance/Achievements
( ) Attitude towards school
Name of School:
Address:
Telephone No.:_____
Principal's Name:_____
School Social Worker:_____

This certifies all of the information stated above is accurate and complete to the best of my abilities.

_____ _____
Signature of Mental Health Professional Date

_____ _____
Signature of Parent/Guardian Date

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AGREEMENT FOR PSYCHIATRIC TREATMENT

Patient Name_____ Date of Birth_____
(please print clearly)

Address: _____

Home Phone#:_____ Cell Phone#: _____

The purpose of this agreement is to give you information about the medications you will be taking and to assure that you and your provider complies with all state and federal regulations concerning the prescribing of controlled substances. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the provider/patient relationship and full agreement and understanding of the risks and benefits.

1. **You should use one** provider to prescribe and monitor your psychiatric medications.
2. You should use **one** pharmacy to obtain all prescriptions and adjunctive analgesics prescribed by your provider.
3. You should inform your provider of all medications you are taking, including herbal remedies, since medications can interact with over-the-counter medications and other prescribed medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is **not** to be used without the explicit permission of the prescribing provider unless an emergency requires your appointment to be deferred one or two days.
5. Prescriptions will be done only during an office visit or during regular office hours. **No** refills of any medications will be done during the evening or on weekends.
6. You must bring back all medications and adjunctive medications prescribed by your provider in the original bottles.
7. If your account is delinquent and payments are not made timely, treatment will be terminated.
8. **You are responsible for keeping your medication in a safe and secure place**. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications.

Medication:

1. I understand that the medication(s) being prescribed for treatment of symptoms of an emotional disorder. The use of the medication(s) at this time may benefit the conditions for which I/we seek treatment. I understand that there is no guarantee that this medication(s) will be beneficial.
2. I understand that arrangements will be made to monitor response to this medication(s) to assess its effectiveness, and it will be discontinued if it is no longer found to be necessary or effective. It will be prescribed in the dose, which is thought to be effective.
3. I understand that all medication(s) may produce side effects, and some side effects may be serious and permanent. I have received instructions regarding this medication(s) and its common and serious side effects. I understand the importance of reporting side effects and unusual reactions to provider.
4. I understand the use of this medication(s) and was given the opportunity to ask questions pertaining to the medication(s).
5. I have told the provider my medical conditions, current medications and history of reactions to medications to the best of my knowledge.
6. I understand the importance of taking this medication(s) per provider's instructions.
7. I consent voluntarily to the prescription of this medication(s) and understand that I may withdraw this consent without prejudice to further treatment.
8. The provider has discussed alternative treatment options (including no treatment).

I agree with above: _____ _____
Signature (patient/Guardian) Date

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Patient Name_____ Date of Birth_____
(please print clearly)

Psychiatrist Communication Form
Primary Care Physician
Mental Healthcare Professional

Consent to Exchange Information

I,_____, authorize THE PSYCHIATRY & PSYCHOLOGY CENTER

and _____
(Primary Care Physician Name, Address & Phone Number)

and _____
(Mental Healthcare Professional Name, Address & Phone Number)

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

_____ _____
Signature (parent or guardian if patient is a minor) Date

_____ _____
Signature (Provider) Date

Robert Garcia, MD
Child, Adolescent & Adult Psychiatrist

Robert Zoltowski, DO
Adult Psychiatrist

William Guy, MD
Adult Psychiatrist

Lauren Walters PA-C
Physician Assistant

Seemin Qureshi PA-C
Physician Assistant

Rany Toma PA-C
Physician Assistant

Patient Information

DSM IV Diagnosis and Code: _____

Recommended Treatment:
_____

_____

_____

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE PATIENT'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT.

_____ _____ Please Check Method
DATE SENT RECEIVED BY (PCP OFFICE STAFF PLEASE INITIAL) Fax ☐ Mail ☐

Please file in Patient's chart

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Patient Name_____ Date of Birth_____
(please print clearly)

Address_____City_____State_____Zip_____

Home Phone#:_____ Cell Phone#: _____

I have been informed of my health insurance mental health benefits, and hereby authorize The PSYCHIATRY AND PSYCHOLOGY Center to bill and collect from my insurance carrier directly, any benefit to which I am entitled for services rendered. I also agree to the release of necessary information to the carrier named above or the managed health care organization utilized by that carrier to process such claim. If for any reason, the insurance company denies or refuses payment,
I am fully aware of my responsibility to pay the standard fees.

Psychiatric Diagnostic Evaluation	$ 350.00
Psychotherapy –patient/family with E&M	$ 125.00
Psychotherapy E&M of an established patient	$ 125.00
Interactive Complexity	$ 150.00
Psychotherapy (45 mins)	$ 165.00
Psychotherapy (60 mins)	$ 185.00
Letter writing, Disability Forms, School Forms	$ 25.00
Prescription Refill (outside of office visit)	$ 10.00

The following are applicable charges to my account:

$35.00 returned checks
$25.00 missed appointment fee or less than 24 hour notice cancellation
Missed therapy appointment fee, less than 24 hour notice cancellation, will be charged the full Therapy Fee

Copy of Medical Records will be charged a fee according to Michigan Public Act 47

Any unpaid accounts after 90 days will be turned over to a collection agency as a means to collect funds. Therefore, patient will also be responsible for a 35% fee added to account once sent to collections.

I have read, understand and accept the financial conditions above.

_____ _____
Patient/Parent/Guardian Date

_____ _____
Responsible Party Social Security #

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GENERAL CONSENT FOR TREATMENT
(HIPPA)

I, the undersigned,

1. Voluntarily consent to treatment as recommended and fully explained to me by staff of The PSYCHIATRY & PSYCHOLOGYCenter and understand that I am free to withdraw my consent and discontinue treatment at any time.
2. Understand that I have rights as a recipient of counseling services, that I have received a description of my rights, and that I may receive additional information about my rights from the Recipient Rights Advisor identified to me.
3. Understand that the confidentiality of records maintained by The PSYCHIATRY & PSYCHOLOGY Center is protected by 42 CRF Part 2 Federal Regulation. Program staff may not disclose any identifying information to outside sources regarding a client's treatment unless the client gives consent. Program staff may release client information without client consent under the following specific conditions:
    - Client threatens to harm self or others;
    - Suspicion of child abuse or neglect;
    - Medical personnel, to meet a bona fide medical emergency when there is immediate threat;
    - Research activities and program evaluation. Personnel may not identify directly or indirectly any individual patient in any report or otherwise disclose patient identities in any manner.
    - Management and financial audits. Examiner must furnish to the program a written statement that no record will be made of patient identifying information unless notice is provided to the program, and, if necessary, setting forth the specific purpose for which identifying information is being retained, how it is to be retained and the contact person; or'
    - Authorized by court order under Sub Part E – Section 2.61 of 42 CFR Part 2.

   Violation of the Federal regulation is a crime. Suspected violations may be reports to appropriate authorities in accordance with Federal regulations. Federal regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime.
4. Acknowledge that any violent or hostile behavior will result in discharge. I understand that possession of a weapon on clinic property is prohibited. I understand that I will be refused a therapy appointment on any day that I come to my a appointment intoxicated. I understand and have been advised of additional program policies regarding conditions under which I may be discharged. I further understand that I have the right to appeal this action to the clinical manager within 15 days from which it occurs.
5. Understand I am to follow through to the best of my ability in developing and achieving treatment goals/objectives, as agreed upon by my therapist and myself. I understand that if I fail to follow through on significant parts of my treatment plan, possibly resulting in harm to myself or others, my therapist may choose to refer me to a more appropriate treatment setting.
6. PAYMENT FOR SERVICES AGREEMENT
   I understand that I have disclosed all information regarding my health insurance. I further acknowledge the insurance information to be accurate and complete. I accept the responsibility for my fees, co-pays, deductibles, charges in insurance, and for all services rendered to me. I authorize The PSYCHIATRY & PSYCHOLOGY Center to submit billing statements to my insurance carrier(s) for the purpose of receiving reimbursement for services until payment is received for all services provided to me. I further understand that I am responsible for the cost of my treatment, and that I will be billed directly if insurance claims are rejected or denied. Finally, I understand that established appointments are reserved for me, and that I may be subject to the usual and customary charge for late arrival, all appointments missed or canceled without 24 hour notice. (EXCEPTION – UNDER CMS GUIDELINES MEDICAID RECIPIENTS CANNOT BE CHARGED ANY FEES). BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED. ACKNOWLEDGE OF PRIVACY PRACTICES The PSYCHIATRY & PSYCHOLOGY Center Notice of Privacy Practices provides information about how protected health information About me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, part 2, if any, and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice that I may change and that I may obtain a revised copy by contacting the privacy officer listed in the Notice.I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction,but if they agree, they will be bound by the agreement. By signing this form, I acknowledge that I have been offered and/or received the PSYCHIATRY & PSYCHOLOGY Center Health Notice of Privacy practices.

WITH MY SIGNATURE I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS NUMBERED 1 THROUGH 6, AND THE GENERAL RELEASE OF INFORMATION.

_____ _____

Client (Parent/Guardian) Signature Date

THE PSYCHIATRY AND PSYCHOLOGY CENTER

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CREDIT CARD CONSENT

I authorize The Psychiatry and Psychology Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ **CVV/CVC** _____

Cardholder Name_____

Billing Address _____

City _____ **State**_____ **Zip** _____

☐ I (we), the undersigned, authorize The Psychiatry and Psychology Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by The Psychiatry and Psychology Center

This authorization will remain in effect until I (we) cancel this authorization.

OR

☐ I (we), the undersigned, authorize The Psychiatry and Psychology Center to charge my credit card, indicated above, for a one-time transaction of: $_____

Card Holder Name (Print): Relationship to Patient:

_____ _____

Card Holder Signature: Patient Name:

_____ _____

Date:

_____ / _____ / _____