FAMILY PSYCHOLOGICAL CENTER, P.A.
CHARLES NICHOLS, PSY.D.
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www.fpcharrison.com

CHILD/ADOLESCENT INTAKE FORM

(This form should be updated with any information changes. Please complete all items.)

Today's Date: _____-_____-_____
Month Day Year

PATIENT INFORMATION

******ARE YOU A LEGAL GUARDIAN OR CUSTODIAL PARENT OF THE CHILD BELOW? ******
*****IF NOT, FORWARD THIS FORM TO APPROPRIATE PERSON. *****

Child's Name: _____ **Child's SS Number:** _____-_____-_____
First Middle Last

Date of Birth: _____-_____-_____ **Age:** _____ **Sex:** ☐M ☐F

Race (check all that apply): ☐Asian ☐American Indian ☐Black ☐Hispanic/Latino ☐White ☐Native Hawaiian ☐ Other _____

School: _____ **Grade:** _____

Name of Parent/Legal Guardian:_____ _____ **Parent/Guardian's SS Number:** _____-_____-_____
Month/Day/Year

Home Address: _____
Street City State Zip Code

Home Phone: (_____) _____-_____ **Parent Cell Phone:** (_____) _____-_____ **Parent Work Phone:** (_____) _____-_____

OTHERS LIVING IN PATIENT'S HOME	DATE OF BIRTH	RELATIONSHIP TO PATIENT (mother, brother, stepsister, grandfather, etc.)

Other Parent's Name: _____ **Other Parent's Phone:** (_____) _____-_____

Other Parent's Address (If Different): _____
Street City State Zip Code

If Divorced, Does Other Parent Have: ☐N/A ☐Sole Custody ☐Shared Custody ☐Visitation ☐Supervised Visitation ☐No Visitation Rights

Relative not Living with Child: _____ **Phone:** (_____) _____-_____

Name of Emergency Contact: _____ **Phone:** (_____) _____-_____

GUARANTOR INFORMATION

Name of Responsible Legal Party/Guarantor: _____
First Middle Last

Guarantor's Relationship to Patient:_____ **Guarantor's Social Security Number:** _____-_____-_____

Guarantor's Date of Birth: _____-_____-_____ **Age:** _____ **Gender:** ☐ M ☐ F
Month Day Year

Guarantor's Address: _____
Street Apt. No. City State Zip

Guarantor's Home Phone: (_____)_____-_____ **Guarantor's Mobile Phone:** (_____)_____-_____

Guarantor's Employer's Name: _____ **Guarantor's Work Address:** _____
Street City State Zip

Guarantor's Work Phone: (_____)_____-_____

REFERRAL SOURCE

How did you hear about us?

_____

HEALTH INFORMATION

Patient's Physician_____ **Physician's Address:** _____
Street City State Zip Code

Describe any medical health problems your child/adolescent currently has._____

_____

CURRENT MEDICATIONS	DOSE/FREQUENCY	WHEN STARTED? (DATE)	WHO PRESCRIBES MEDICATION?

Describe any serious *PAST* medical illnesses and injuries with approximate dates. _____

_____

List any prior surgeries with dates._____

Has the child received prior mental health assessment or therapy? ☐ Yes ☐ No **If yes, list all dates/periods of treatment below.**

Mental Health Treatment Dates (Begin/End)	Facility/Treatment Provider	Type of Treatment (Medication, Therapy, Hospitalization)	Reason for Treatment/Diagnosis	Was Treatment Successful?

Has the child/adolescent been hospitalized for psychiatric treatment? ☐ Yes ☐ No **If yes, how many times and when?** _____

What was/were the reason(s) for the child's mental health hospitalization(s) (if applicable)? _____

_____

SERVICES REQUESTED

Please indicate the type of services you are interested in (check all that apply):

☐ Psychological Testing ☐ Individual Treatment/Counseling ☐ Family Therapy ☐ Diagnostic Clarification
☐ Learning Assessment ☐ Personality Assessment ☐ Court, Legal, or Custody Issues ☐ Other_____

Please describe your primary reason for seeking services. _____

_____

CURRENT SYMPTOMS

Rate the degree to which your children/adolescent has experienced the following symptoms and how long each has occurred.

0 = None, Not at All 1=Mild, Rarely a Problem 2=Moderate, Sometimes It's Difficult 3=Severe, I Can Barely Stand It

Symptom	0-3	How Long?
Prolonged Sadness or Depression		
Loss of Energy		
Social Withdrawal/Avoiding Interaction with Others		
Sleeping Too Much/Sleeping Too Little *(circle one)*		
Negative View of Future/Hopelessness		
Weight Loss/Gain (circle one)		
Difficulty Making Decisions		
Appetite Increase/Decrease *(circle one)*		

Symptom	0-3	How Long?
Alcohol Misuse		
Drug Misuse		
Oppositional and Defiant Attitudes		
Decreased Academic Performance		
Conflict (parents, siblings, teachers) *(circle)*		
Lack of Friends/Negative Friends *(circle)*		
Sexual Acting Out		
Hallucinations (hearing voices, seeing things) *(circle)*		

Excessive Joy or Grand Feelings		
Risky Behaviors (splurges, drive fast, stealing) *(circle)*		
Racing Thoughts		
Pressure to Talk More than Usual		
Abnormally High Physical Activity or Energy		
Prolonged Anxiety/Nervousness		
Fear of Being Criticized in Public or Judged		
Muscle Tension		
Forgetfulness (losing things, forget appointments) *(circle)*		
Difficulty Relaxing		
Panic or Anxiety Attacks		
Nightmares		
Memories of Traumatic Event(s)		
Bedwetting/Refusal to Sleep Alone *(circle all that apply)*		
Fear of Objects/Situations/Crowds *(circle all that apply)*		
Constant and Disturbing Worries		
Rituals-Compulsions (counting, ordering, echoing) *(circle)*		
Developmental Delay (speech, motor, social skills) *(circle)*		
Math/Reading/Writing Problems *(circle all that apply)*		
Failing Grades/Skipping School *(circle all that apply)*		

Physical Violence/Aggression		
Suspicious Thoughts/Difficulty Trusting Others		
Temper Problems/Rage		
Physical Problems that Increase with Stress		
Fear of Having a Disease		
Short Attention Span		
Difficulty Completing Tasks		
Poor Organization		
Difficulty Following Directions		
Difficulty Sitting Still/Restlessness		
Excessive Talking		
Not Thinking Ahead about Consequences		
Legal Problems/Probation *(circle those that apply)*		
Twitches/Tics *(circle those that apply)*		
Worry about Gaining Weight/Restricting Calories		
Inducing Vomiting/Misuse of Laxatives *(circle)*		
Self-Mutilation/Cutting		
Side Effects from Medication(s)		
Other:		
Other:		

INSURANCE AND WORK INFORMATION

A copy of the patient's insurance card(s) is(are) required to confirm your insurance benefits and file claims.
Please bring all active insurance card(s) when you return this form.

Do you plan to use insurance? ☐Yes ☐No **If yes, please complete information below using your insurance card(s).**

PRIMARY Insurance Company: _____

Name of Insured on Card: _____
First Middle Last

Group Number:_____ **Member Number:** _____

SECONDARY Insurance Company: _____

Name of Insured on Card: _____
First Middle Last

Group Number:_____ **Member Number:** _____

Who is Responsible for Payment of Services? _____
First Middle Last

Relationship of Responsible Party to Patient: _____

Employer and Address: _____
Company Street City State Zip

Landlord: _____ **Phone #:** (_____)_____-_____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of his or her child/adolescent. I further expressly agree and acknowledge that my signature on this document authorizes my child's provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____**, hereby authorize** _____
Name of Parent/Guarantor Name of Insurance Company

to pay and hereby assign directly to Family Psychological Center all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred, including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services, and I hereby authorize the release of my dependent's pertinent healthcare information to insurance carriers. I understand and agree that I am ultimately responsible for the balance of my dependent's account, regardless of insurance status. I further acknowledge that any insurance benefits, when received by and paid to Family Psychological Center, P.A. will be credited to my account, in accordance with the above said assignment.

I have read all the information on these sheets and have completed all of the answers that apply to me and my dependent. ***I also certify that I am the legal guardian of the child/adolescent and have legal authority to make healthcare decisions for the dependent.*** I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in the above information, including the dependent's address, my employment, any and all contact information, or changes in guardianship/parental custody of the dependent.

_____ _____ _____
Signature of Parent/Guarantor Printed Name of Parent/Guarantor Date

NOTICE OF OFFICE POLICIES FOR CHILD AND ADOLESCENT PATIENTS

CONFIDENTIALITY
Confidentiality is a fundamental priority at FPC, P.A. The information your child discloses to his or her therapist remains confidential except when your child provides assent to release the information AND you provide signed authorization to release it (such as to your physician) or when legal or ethical principles apply. Confidentiality must be breached if any form of abuse involving a child, elder, or other incapacitated person is disclosed. Other instances include suicidal intentions, a specific harm against another person, or a court order. You should openly verbalize any concerns about confidentiality with your child's treatment professional. By signing below, you acknowledge receiving a copy of the "Patient Notice of Privacy Practices" from the Family Psychological Center, P.A. Which can be obtained from our office or our website at www.fpcharrison.com.

In the case of child and adolescent treatment, the legal guardian or parent usually has a legal right to access treatment information. However, one key ingredient in successful therapy is a zone of privacy. Although children and adolescents will be told at the outset that serious threats of harm to self or others cannot be kept confidential, they must otherwise have confidence that their therapy conversations will remain private before they will consider disclosing their deeply personal concerns and issues with their therapist. Few things carry more potential to disrupt treatment than the child or adolescent fearing or finding out that information was shared without his or her knowledge. If serious threats of harm or safety arise during therapy, regardless of whether a minor assents to have information disclosed to a parent to protect their safety, it makes both clinical and ethical sense to tell the child/adolescent—beforehand, if possible—what information needs to be shared, and when. Ideally, the child/adolescent would be present in the room for such conversations. Finally, in some cases, your child's therapist may believe strongly that revealing confidential information to a parent or others could harm your child or be destructive to his or her treatment. A therapist's refusal to disclose in such a case, even in the face of a parent's request or mandate, may be legally supportable. If your child's therapist believes that disclosure of treatment information to you or others (e.g., attorney or court) would harm your child, your child's therapist will explain this to you and ask you to withdraw your request in order to preserve the therapy relationship and/or to avoid potential actions to preserve your child's treatment information, even if mandated by subpoena to disclose.

COURT OR LEGAL INVOLVEMENT
Unless the purpose of your child's services is clearly disclosed by you in writing on this intake form as related to Court, Legal, or Custody Issues (page 2), your child's therapist will serve as a treatment professional, not a forensic expert or court evaluator. Your child's therapist cannot ethically serve in both capacities. Once treatment services begin (that is, at the time of the initial appointment), your child's treating therapist cannot later serve as a forensic expert for legal purposes. Further, confidentiality in a treatment relationship (see above) requires a firm zone of privacy that will be established from the outset with your child. On the other hand, if you request services related to Court, Legal, or Custody issues on this intake form, your child will be informed from the outset (before starting the intake session) that the purpose of his or her services is related to legal issues and that anything he or she discusses may be shared with others in a written report and/or expert testimony.

Unless the purpose of seeking services is clearly disclosed in writing as related to Court/Legal/Custody Issues on this intake form (page 2), the parent or guardian agrees that he or she will refrain from requesting or mandating access to the child's confidential treatment records or conversations for legal purposes, including by subpoena or other legal actions. **If the parent or guardian chooses to request or legally mandate release of the child's confidential treatment information, despite his or her previous agreement to the treatment contract and its stricter confidentiality limits, the requesting parent or guardian agrees to tender a fee of $1,200.00 in cash or check to Family Psychological Center, P.A. at the same time that that the request or subpoena is served to the therapist and/or Family Psychological Center, P.A.**

TRAINING INSTITUTION
FPC, P.A. provides doctoral internship training accredited by the American Psychological Association. As such, some staff members are doctoral interns or postdoctoral residents. If your child's treatment provider is an intern or resident, your child's treatment information will be confidentially reviewed by the clinician and his or her clinical supervisor, a licensed psychologist on staff at our practice, on a frequent basis. The purpose of this review is to enrich your child's treatment services and provide additional training.

ASSIGNMENT OF HEALTHCARE BENEFITS
I authorize my insurance carrier to assign all health care benefits, if applicable, to Family Psychological Center, P.A. I also authorize release of my child's health care information necessary to process all insurance claims.

PARENT/GUARDIAN INVOLVEMENT
The **custodial parent and/or legal guardian must be present** for the child's initial appointment to give legal consent to provide services and furnish information about the child's symptoms, history, and other pertinent information. If the child has two custodial parents (as in shared custody after a divorce), **both parents must attend** the intake session **or** the parent who does not attend must provide written consent to treat the child. This form can be obtained at our office and must be signed at our office *at least 2 days* before the child's initial appointment.

PAYMENT POLICY
Co-payments are to be collected at the time of your child's appointments, just before sessions begin. We accept cash and checks only **(no credit cards or debit cards)**. All mental health services are directly charged to the patient or responsible party. If your child's provider is contracted with your insurance carrier, we will accept the negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Some billable services may be required that are not reimbursed by insurance but are time consuming for your provider (e.g., writing letters, testing more than allowable hours, court testimony—if in a legal case). We do not bill insurance for court-related evaluations and therapy; services provided in a legal context must be paid in full before services are provided. If non-billable services are requested or required, you will be advised beforehand, if possible. Your payment is expected in full at the time of the service.

CANCELLATION POLICY
Our office requires that if you need to cancel or reschedule your child's appointment, we must receive notice from you at least 24 hours before the appointment. This allows us time to contact another client and schedule in the vacated appointment slot. We reserve the right to charge an **$80.00 fee** for a "no show" appointment or an appointment canceled less than 24 hours in advance, which must be collected before your child's next appointment is scheduled. Cancellations must be made in person or by phone, not email. Voicemails must be left on our office line (870-743-6225) if the phone is not answered by our staff at the time you call to reschedule or cancel.

I HAVE READ, UNDERSTAND, AND FULLY AGREE TO ABIDE BY THE ABOVE RELEASE OF HEALTHCARE INFORMATION, PAYMENT ARRANGEMENTS, CANCELLATION POLICY AND FEES, COURT OR LEGAL INVOLVEMENT, AND ALL OTHER OFFICE POLICIES FOR MY CHILD AS EXPLAINED IN THE "NOTICE OF OFFICE POLICIES FOR CHILD AND ADOLESCENT PATIENTS" ON PAGE 4 OF THIS INTAKE FORM.

FURTHER, BY SIGNING BELOW, I GIVE MY INFORMED WRITEN CONSENT TO ALLOW PSYCHOLOGICAL TREATMENT SERVICES TO MY CHILD OR ADOLESCENT.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____
First Middle Last

PATIENT NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receiving a copy of the "Patient Notice of Privacy Practices" from Family Psychological Center, P.A. This is available from our office or at www.fpcharrison.com.

_____ _____
Child/Adolescent Patient's Name Date of Birth

_____ _____
Signature of Patient or Authorized Representative Date

CONSENT TO CALL

With permission, we remind patients by phone about appointments when possible. If patients are not available, we do not leave messages unless the patient or authorized representative authorizes us to do so. Initial the methods of contact you will permit.

_____ I consent and authorize Family Psychological Center, P.A. to call my residence for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to leave a message at my residence for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to call my cell phone for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to leave a message on my cell phone for appointment reminders.
_____ I consent and authorize Family Psychological Center, P.A. to call my place of employment for appointment reminders.

I understand and allow Family Psychological Center, P.A. to contact me by means of the initialed methods above. I understand that phone contact may become known by anyone with access to my phone or caller ID systems.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient or Authorized Representative Date

We appreciate your interest in our professional services and look forward to working with you and your child!

Remember: Take insurance card(s), if applicable, when you return this paperwork to our office.

OFFICE USE ONLY

Date Received _____

Received By _____

Incomplete Sections _____

Notes_____