Freedom Psychiatry

_____
DATE

CHILD & ADOLESCENT INTAKE ASSESSMENT FORM

Referred by: _____ **Phone:** _____

Address: _____

_____ Pediatrician _____Family Physician _____MD/DO Specialist _____

_____Psychologist _____Social Worker _____Nurse Practitioner _____Other _____

IDENTIFICATION

Name: _____ **DOB:** _____ **Age:** _____

Preferred Name: _____ **Gender:** _____**M** _____**F** **Identifies as:** _____

Address: _____ **City:** _____**State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Preferred Pharmacy: _____ **Address:** _____

Phone: _____

PARENTAL OR GUARDIAN INFORMATION

Mother's Name: _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Occupation: _____ **Work Phone:** _____

Father's Name: _____ **Age:** _____

Address *(if different)*: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Occupation: _____ **Work Phone:** _____

SOCIAL SERVICES AGENCY *(if applicable)* **Is agency the Legal Guardian** _____ **Y** _____**N**

Agency Name: _____ **Contact Person:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

SCHOOL INFORMATION *(Complete only those fields that apply)*

School Name: _____ **Grade:** _____ **Phone:** _____

Special Education: _____**Y** _____**N** *If yes, explain:*

_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Principal: _____ **Phone:** _____

Guidance Counselor: _____ **Phone:** _____

Psychologist: _____ **Phone:** _____

Social Worker: _____**Phone:** _____

If receiving Special Education Services, what services?

_____**Resource Room** _____**Speech-Language** _____**Occupational Therapy** _____**1 to 1 Para**

_____**Physical Therapy/Ed** _____**Other:** _____

FAMILY MEMBERS RESIDING IN THE HOME

NAME	DOB	AGE	GENDER	RELATIONSHIP
			M F	
			M F	
			M F	
			M F	
			M F	

MENTAL HEALTH HISTORY **HOSPITALIZATIONS?** _____**Y** _____**N If** yes, how many? _____

HOSPITALS	DATE		REASON

PSYCHOTHERAPY – *Current and Past*

Clinician Name: _____ **Dates:** _____ **to** _____

Type: _____MD/DO _____PhD _____SW _____Masters **Phone:** _____

Clinician Name: _____ **Dates:** _____ **to** _____

Type: _____MD/DO _____PhD _____SW _____Masters **Phone:** _____

PRESCRIBER – *Physician or Nurse Practitioner (Current or Past)*

Clinician Name: _____ **Dates:** _____ **to** _____

Type: _____Psychiatrist _____Family Physician _____Pediatrician _____Nurse Practitioner
Phone: _____

Clinician Name: _____ **Dates:** _____ **to** _____

Type: _____Psychiatrist _____Family Physician _____Pediatrician _____Nurse Practitioner
Phone: _____

PSYCHIATRIC MEDICATION HISTORY **Current Psychiatric Medications: _____Y _____N**

Medication	Dose	Start Date	Side Effects

Previous Psychiatric Medications: _____Y _____None

Medication	Dose	Start Date	End Date	Side Effects

Authorization for the Release of Protected Health Information

PATIENT NAME: _____ DOB: _____

PARENT OR LEGAL GUARDIAN: _____

Authorization for the Release of Protected Health Information

PATIENT NAME: _____ DOB: _____

PARENT OR LEGAL GUARDIAN: _____

This form, when completed and signed by you, authorizes the Freedom Psychiatry Services PLLC Providers to release and exchange health information from you or your child's clinical record.

Please list names of providers(s), agency(s) phone and/or fax number below:

1.
_____

2.
_____

3.
_____

This information will include:

_____Copies of Progress Notes
_____Treatment Plan and Summary (Written & Verbal)
_____All of the Above
_____Testing/Lab Results
_____Other (Specify): _____
_____

The purpose of this request is for:

_____Insurance Purposes _____Medical Treatment _____Educational Placement _____The Patient
_____Legal Reasons _____Discharge Planning _____Other (explain) _____

_____

This authorization shall remain in effect for _____1 Year or _____Until the End of Treatment.

Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this entity informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws.

I understand that I have no obligation to disclose the above information and that I may revoke this consent at any time by notifying this office in writing at the address below. Such revocation will not extend to prior release of information on the basis of this authorization. I further understand that this office has no control over information once it has been released and in consideration of this consent, I release Freedom Psychiatry Services, PLLC, from any and all liability arising therefrom.

_____ _____

Signature of Patient or Legal Guardian **Date**

NO SHOW & CANCELLATION POLICY

Freedom Psychiatry Services, PLLC Cancellation and No-Show Policy:
1. After one (1) missed (No-Show) scheduled appointment, the patient will be phoned and given a reminder.
2. After two (2) missed scheduled appointments, the patient will be discharged from the practice.
3. ALL NO-SHOW APPOINTMENTS ARE SUBJECT TO A $50 NO-SHOW FEE

It is the patient's responsibility to notify Freedom Psychiatry Services, PLLC of a cancellation at least 24 hours (1 day) in advance of the scheduled appointment to avoid the No-Show Fee. Appointments cancelled less than 24 hours in advance are considered a No-Show and will be charged a $50.00 fee.

Please arrive 15 minutes prior to your appointment to complete the check-in process. If you arrive 10 after your scheduled appointment time, you may be asked to reschedule and be charged a no-show fee.

COVID19 WAIVER

• Fever • Fatigue • Dry Cough • Difficulty Breathing

I agree with the following:

• I understand the above symptoms and affirm that I and all household members do not currently have nor have experienced the symptoms listed above within the last 14 days.

• I affirm that I and all household members have not been diagnosed with COVID-19 within the past 30 days. I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the past 30 days.

AUTHORIZATION TO BILL INSURANCE & PAYMENT AGREEMENT

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. Payment agreements will be automatically arranged if your account balance exceeds $200.

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

PRIVACY NOTICE

While evaluating and treating you, Freedom Psychiatry PLLC may obtain Protected Health Information (PHI) from you and from other medical and non-medical informants. With your signed Treatment Consent, Freedom Psychiatry PLLC may use and disclose the minimum necessary information for purposes of Treatment, Payment, and Healthcare Operations (TPO). Examples of treatment purposes include sharing

information with other professionals, relatives, or friends involved in your care, arranging a hospitalization, placing diagnoses on order forms for laboratory or other tests, telephoning prescriptions or providing information to third parties necessary to obtain insurance coverage for prescription drugs, etc. Examples of payment purposes include submitting information electronically or on paper to a third-party payer such as Blue Cross Blue Shield, to a utilization review professional to have services authorized for payment and to a collection agency. Examples of healthcare operations include quality assurance activities. (We do not disclose patient names to anyone for marketing purposes.) An appointment reminder message may be left on your voicemail or email account.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have no obligation to disclose the above information and that I may revoke this consent at any time by notifying this office in writing at the address below. Such revocation will not extend to prior release of information based on this authorization. I further understand that this office has no control over information once it has been released and in consideration of this consent, I release Freedom Psychiatry Services, PLLC, from all liability arising therefrom.

This form, when completed and signed by you, authorizes the Freedom Psychiatry Services PLLC Providers to release and exchange health information from you or your child's clinical record. Please see Front Desk associate at any time you would like to update.

REASON FOR DISMISSAL

The American Medical Association has established guidelines regarding when a provider may or may not dismiss a client based on its Code of Ethics. In addition, many states have laws about the circumstances under which a doctor may terminate a patient relationship. They are the following:

- Patient non-compliance with treatment: When the patient fails to follow the treatment, recommendation established by the provider. Which is important to collaborate to orchestrate an appropriate treatment plan.
- Patient's failure to keep appointments: Patients make appointments, then cancel them at the last minute, or do not show up at all. Each client will be asked to pay an NCNS Fee of $ 50.00
- Patient's rude or obnoxious behavior: No patient should ever be rude or obnoxious. It's a form of abuse.
- Non-Payment of bills.
- If care is too great that providers feel your needs can no longer be met.
- If doctor's practice is closing.

If you are dismissed, we will make sure you have a 30-day refill and will provide you with a written letter explaining dismissal. Again, our office is rapidly growing, and we feel that it is important to set guidelines so that we can focus on providing you with the best care possible.

Disclaimer: This is an update form to acknowledge that you have read and understand the policies. If you would like a full copy of the policies, please advise the staff.

By my initials, I acknowledge that I have received a copy of the update for Freedom Psychiatry, PLLC policies, and I understand I can receive a copy of the full policy at my request.

_____ NO SHOW & CANCELLATION POLICY

____ COVID 19 WAIVER

_____ AUTHORIZATION TO BILL INSURANCE & PAYMENT AGREEMENT

_____ INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

____ PRIVACY NOTICE

____ AUTHORIZATION FOR THE RELEASE OF PROTECTED INFORMATION

____ RECEIVED NOTICE OF POLICY & OBTAINED A COPY TO KEEP

____ REASON FOR DISMISSAL

By my signature, I acknowledge that I have read, understand, and agree with the policies of Freedom Psychiatry, PLLC.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE