Your Family Psychiatrist

CHILD FORM

Dear New Patient,

We are glad that you have chosen Your Family Psychiatrist to provide this important aspect of your child's health care. We are committed to providing your family with the most caring, professional, and confidential services possible. Our unique office arrangement is meant to bestow a more comfortable and relaxed environment than is customary in most physician offices. The first appointment is a complete Psychiatric Evaluation, which entails reviewing medical, psychiatric, social, and family history. Please flip the light switch in the waiting room that corresponds to your clinician upon arriving for your initial and all future appointments.

1) INITIAL PAPERWORK

The Child Intake Questionnaire is required to be completed **prior** to the appointment. The doctor needs ALL the requested information in order to make an accurate differential diagnosis. If you arrive late or do not have the paperwork completed by your appointment time, the evaluation may be abbreviated in order to stay on schedule and not delay the next patient's appointment. We try our best to stay on schedule for our patients so you are never waiting long to see your doctor!

2) FINANCIAL POLICY

Payment is expected prior to being seen by your psychiatrist or masters level counselor. We accept all major credit cards and cash if paid with exact change. We do not keep cash at our office. The following is a brief list of services:

Psychiatric Initial Evaluation - $325.00
Psychiatric Follow-up - $160.00
Counselor Follow-up - $115.00

Regarding Insurance

We will provide you with documentation necessary to file an insurance claim on your own if your insurance allows us to do so. Your insurance plan may reimburse you directly. Please contact your insurance company to determine your benefits. We do not accept assignment of benefits and do not participate in any network. Your Family Psychiatrist will be considered an out-of-network provider by your insurance plan.

Missed Appointments

Unless canceled at least 2 business days in advance (48 hours prior notice not counting weekends), our policy is to charge for missed appointments at the full fee. Your appointment time is reserved for you. Please help us to serve you better by keeping scheduled appointments.

I have read, acknowledge and agree to abide by the above financial policies regarding service fees and missed appointments.

____________________ Name	____________________ Signature	__________ Date

Child Intake Questionnaire

DEMOGRAPHIC INFORMATION

Patient Legal Name:	Preferred Name:	Date:
Date of Birth:	Age:	Sex: ◯ Male ◯ Female
Address:	City: State:	Zip:
Father's Name:	Mother's Name	
Father's Address: ◯ Same as above	Mother's Address: ◯ Same as above	
Father's Phone: ◯ Home ◯ Cell ◯ Work	Mother's Phone: ◯ Home ◯ Cell ◯ Work	
Father's Email Address:	Mother's Email Address:	
Parents: ◯ Married ◯ Divorced ◯ Separated ◯ Never Married		
Child is living with?	Appointment reminders? ◯ Email ◯ Text ◯ Both	
Referred by?	May we acknowledge the referral? Yes No	

CHIEF COMPLAINT

Briefly describe your reason for seeking treatment.

Describe main symptoms.

Please check any areas below which have been worsened due to your child's current problems.

- ◯ School/work performance
- ◯ Relationship with family
- ◯ Interest in keeping up appearance
- ◯ Ability to control temper
- ◯ Ability to carry out usual leisure interests/hobbies
- ◯ Ability to plan for future and set goals
- ◯ Relationships with friends
- ◯ Ability to manage usual chores at home
- ◯ Ability to control behavior
- ◯ Extracurricular activities
- ◯ Relationships with teachers/school
- ◯ Relationship with legal authorities

PATIENT PSYCHIATRIC AND MEDICAL HISTORY

HISTORY OF PRESENTING ILLNESS

When did these symptoms begin?

Did something occur to precipitate them?

Have there been symptom-free periods?

PAST PSYCHIATRIC HISTORY

Has patient been treated for problem in the past?

When did treatment first begin?

What kind of treatment occurred?

Individual psychotherapy? If yes, when and with whom?

Group/Family/Couples psychotherapy? If yes, when and with whom?

Has patient ever been psychiatrically hospitalized? If yes, when how, and under what circumstances?

Has patient ever hurt himself/herself in any way? For example, cutting or burning self. If yes, when, how, and under what circumstances?

Has patient ever thought of or attempted to commit suicide? If yes, when, how, and under what circumstances?

MEDICAL HISTORY

Current and prior medical problems:

Medical hospitalizations / surgeries:

Known drug allergies:

Primary Care Physician:	Last physical exam:
Address/Phone:	Immunizations current? ○ Yes ○ No

Describe current eating habits:

Describe current sleeping habits: (How many hours per night? Wake up during night? How long does it take to fall asleep?)

Describe current exercise habits:

PAST MEDICATIONS

NAME OF MEDICATION	*DOSAGE*	*WHY PRESCRIBED*	*WHO PRESCRIBED*	*COMMENTS (HELPFULNESS/SIDE EFFECTS)*

CURRENT MEDICATIONS				
NAME OF MEDICATION	DOSAGE	WHY PRESCRIBED	WHO PRESCRIBED	COMMENTS (HELPFULNESS/SIDE EFFECTS)

Please comment on any substance abuse (drugs/alcohol).

What	When did you start	How much did you use	Last use	What did it do for you?

Please mark any that the patient has or has had and include dates as best you can.

- ◯ Head injury/Loss of consciousness
- ◯ Seizures/Convulsions
- ◯ Other neurological problems
- ◯ Ear, Nose, or Throat problems
- ◯ Dental problems
- ◯ Asthma
- ◯ Chest problems
- ◯ Stomach or bowel problems/soiling
- ◯ Urinary or bladder/wetting
- ◯ Heart problems
- ◯ Rheumatic fever/strep infections
- ◯ Liver/Kidney problems
- ◯ Skin problems
- ◯ Joint/limb problems
- ◯ Hearing/vision problems
- ◯ Growth/endocrine problems
- ◯ Gynecological/menstrual problems
- ◯ Childhood measles/mumps

FAMILY HISTORY

Please give the names, ages, and relationships of people living in the home:

Other immediate family members not living in the home:

FAMILY PSYCHIATRIC HISTORY

Has any family member had any of the following? Please indicate which family member.

- ◯ Depression
- ◯ Mania/Bipolar Disorder
- ◯ Suicidal thoughts/Urges/Behaviors
- ◯ Anxiety
- ◯ Panic
- ◯ Obsessions/Compulsions
- ◯ Rituals
- ◯ Movement Disorders
- ◯ Tics
- ◯ Unusual noises/vocalizations
- ◯ ADHD
- ◯ Eating Disorder
- ◯ Learning Disability
- ◯ Coordination problems
- ◯ Intellectual Disorder
- ◯ Autism/Asperger's Disorder/PDD
- ◯ Sleep Disorder
- ◯ Drug Use
- ◯ Alcohol Use
- ◯ Psychosis
- ◯ Legal Problems
- ◯ Psychiatric hospitalizations
- ◯ Other ____________

Please elaborate on above as needed:

Please provide information about significant medical issues on the FATHER'S side:

Please provide information about significant medical issues on the MOTHER'S side:

Describe your child's activities, interests, hobbies, skills, strengths:

Please use the remaining space to describe any other comments, questions, or concerns.

Problem Behavior Checklist: Does your child have any of the following problems? Please check all that apply.

	In the past	Occasionally	Often	Very Often
Short attention span				
Impulsivity (acts before thinking)				
Won't follow rules/directions				
Irritable, poor frustration tolerance				
Easily riled up				
Picks on others, bullies				
Feels picked on				
Deliberately tries to annoy people				
Easily angered, bad temper				
Gets out of control				
Gets violent and aggressive				
Steals				
Cries easily				
Lack of interest in activities				
Isolates self from others				
Sadness				
Poor appetite				
Problems getting to sleep				
Early morning awakening				
Self-injurious/abusive behaviors				
Excessive sleepiness				
Weight gain/loss				
Worries a lot				
Fear of the dark				
Other specific fears (heights, etc)				
Reluctance to go to school/work				
Repeated unwanted thoughts				
Compulsive behaviors				
Rituals (has to repeat the same action)				
Hair pulling				

Your Family Psychiatrist

Consent for Treatment

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to and authorizes services by Your Family Psychiatrist, PLLC. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Consent for the services outlined above.
2. Be informed of and participate in the selection of treatment modalities.
3. Receive a copy of this consent.
4. Withdraw this consent at any time.

____ _______________________

Name of the parent, legal guardian, or conservator Relationship to the patient

____ _______________________

Signature Date

Your Family Psychiatrist

Acknowledgement of Receipt of Office Policies 2019 and HIPAA Notice of Privacy Practices

Please sign below to confirm that you have received the Your Family Psychiatrist Office Policies and HIPAA Notice of Privacy Practices.

I acknowledge receipt of, and agree to follow, these office policies. I also acknowledge receipt of the HIPAA Notice of Privacy Practices. I have had an opportunity to call and ask questions about the policies and practices:

____	____
Name of Patient or Legal Guardian (please print)	Relationship to patient
____	____
Signature	Date

Consent for Electronic Communications

I understand that the office policies allow Your Family Psychiatrist to communicate with me via email and other electronic media regarding matters related to my care. I have provided you with my email address and telephone number, and I acknowledge that I am responsible for keeping my email address and telephone number updated. I am able to receive information electronically and store it securely away from any public computer. I acknowledge that I can change or withdraw my consent to electronic communications at any time.

I understand that I may elect now to opt out of automated appointment reminders by placing my initials by the appropriate OPT OUT election below:

I elect to OPT OUT of automated email appointment reminders ___________ (initials)

I elect to OPT OUT of automated text appointment reminders ___________ (initials)

I elect to OPT OUT of automated telephone appointment reminders ___________ (initials)

____	____
Name of Patient or Legal Guardian (please print)	Relationship to patient
____	____
Signature	Date

Your Family Psychiatrist

Credit Card Charge Authorization

I understand that full payment is required at the time of service by either cash or credit card. Full payment is also required for missed appointments and cancellations with less than 48 hours prior notice (not counting weekends).

I also understand that the financial responsibility for services provided is mine, and that I must file for any insurance reimbursement to which I may be entitled because Your Family Psychiatrist, PLLC will not file insurance claims on my behalf.

I understand that the credit card listed below will be charged for services rendered and for the missed and cancelled appointments with less than a 48-hour notice. If the credit card charge is denied, I will be billed separately for the appointments. Your Family Psychiatrist will not schedule any further appointments until I pay all outstanding balances.

I agree to call and notify the receptionist in advance of my next scheduled appointment if my address, phone number, or responsible party has changed.

I hereby authorize Your Family Psychiatrist, PLLC to charge my credit card for services rendered to me or the patient whose name appears below (and for appointments missed or cancelled with less than a 2-busines- day-notice) at a rate of $325 for the initial appointment or $160 for each follow-up appointment. Counseling with our masters level therapist/counselor is $115 per appointment.

Credit Card No.:________________________________ Security Code:_______ Exp. Date:_____________

Name (as printed on card):____

Billing Address (shown on the card statement): ____

City:_______________________ State:_________________ Zip Code:__________

By signing below I am authorizing Your Family Psychiatrist, PLLC to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

____ ________________________

Patient's Name Date

____ ________________________

Responsible Party's Name Date

____ ________________________

Responsible Party's Signature Date

TELEPSYCHIATRY/TELECOUNSELING INFORMED CONSENT

Telepsychiatry/telecounseling is the delivery of psychiatric/counseling services using interactive audio and visual electronic systems where the psychiatrist/counselor and the patient are not in the same physical location. Your Family Psychiatrist, PLLC allows its psychiatrists to perform telepsychiatry, however your psychiatrist may not be able to prescribe controlled substance medications until after a face-to-face appointment. Your Family Psychiatrist predominantly uses Doxy.me, LLC to provide telepsychiatry/telecounseling services, but your psychiatrist/counselor may use an appropriate alternative if there is a poor connection or error. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Telepsychiatry/Telecounseling Benefits:

- Increased accessibility to psychiatric/counseling care.
- Patient convenience.

Potential Telepsychiatry/Telecounseling Risks:

- Information transmitted may not be sufficient (*e.g.*, poor resolution of video) to allow for appropriate medical decision-making by my psychiatrist/counselor.
- Delays in psychiatric/counseling evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If I decide that the benefits outweigh the risks, I may request telepsychiatry/telecounseling sessions when I schedule follow-up appointments. If my psychiatrist/counselor agrees, I will be scheduled for a telepsychiatry/telecounseling session, and I will be sent an internet link (to http://Doxy.me) with instructions to log into the “waiting room” immediately prior to my scheduled appointment.

My Rights:

(1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry/telecounseling.
(2) I understand that all the Texas rules and regulations which apply to psychiatry/counseling also apply to telepsychiatry/telecounseling.
(3) I understand that my psychiatrist/counselor has the right to withhold or withdraw consent for the use of telepsychiatry/telecounseling at any time during the course of my care.
(4) I understand that I have the right to withhold or withdraw my consent for the use of telepsychiatry/telecounseling at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my psychiatrist/counselor.

My Responsibilities:

(1) I understand that I must be physically within Texas (including offshore State waters) to be eligible for telepsychiatry/telecounseling, and my psychiatrist/counselor can send prescriptions for medications only to Texas pharmacies or addresses. I will inform my psychiatrist/counselor as soon as my session begins of my physical location.
(2) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have working camera and audio input so that my psychiatrist/counselor can see and hear me in real time.
(3) I will not record any telepsychiatry/telecounseling sessions without written consent from Your Family Psychiatrist, PLLC, and I understand that my psychiatrist/counselor will not record any of our telepsychiatry/telecounseling sessions without my written consent.
(4) I will inform my psychiatrist/counselor as soon as my session begins if any other person can hear or see any part of our session.
(5) If I lose my connection during a session, I will immediately attempt to log back into the http://Doxy.me “waiting room”.
(6) If the audio I am receiving during a telepsychiatry/telecounseling session is not complete and clear, I will attempt to let my psychiatrist/counselor know or telephone Your Family Psychiatrist, PLLC to schedule a new appointment.

Patient Consent to the Use of Telepsychiatry/Telecounseling

I have read and understand the information provided above regarding telepsychiatry/telecounseling. I hereby give my informed consent for the use of telepsychiatry/telecounseling in my medical care and authorize my psychiatrist/counselor to use telemedicine in the course of my diagnosis and treatment. I agree to hold Your Family Psychiatrist, PLLC and its psychiatrists/counselors harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

____ ____________________

Printed name Date

____ ____________________

Signature of patient (or parent, legal guardian, or conservator) (Relationship to patient)