Registration Form
Psychology Consultation Specialists

Date_____

Child's Information

Patient Name (Print) _____ _____
Last Name First Name Initial

Date of Birth _____ Age: _____ **Gender:** Female ◯ Male ◯

Street Address: _____ City: _____ State: _____ Zip: _____

Parent 1 Name: _____ Email address: _____

Phone(s) Cell ◯ Work ◯ _____ Messages okay? Y ◯ N ◯

Parent 2 Name: _____ Email address: _____

Phone(s) Cell ◯ Work ◯ _____ Messages okay? Y ◯ N ◯

Parent 2 Address (if different): _____ City: _____ State: _____ Zip: _____

Primary Insurance

Primary Insurance Company_____ Phone: _____

Ins Claims Address _____ City:_____ State: _____ Zip:_____

Policy/ID #_____ Group/Plan#: _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name:_____ Relationship: _____
Last Name First Name Initial

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

Soc. Sec#:_____ Employer:_____ **Date of Birth:** _____
REQUIRED

Secondary Insurance

Secondary Insurance Company_____ Phone:_____

Ins Claims Address _____ City:_____ State:_____ Zip:_____

Policy ID # _____ Group/Plan #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name:_____ Relationship: _____
Last Name First Name Initial

Address_____ City:_____ State:_____ Zip: _____

Soc. Sec#:_____ Employer:_____ **Date of Birth:**_____
REQUIRED

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____
Responsible Party Signature Relationship Date

info@pcsmn.com
www.pcsmn.com

PSYCHOLOGY CONSULTATION SPECIALISTS PLLC
CHILD | TEEN | FAMILY | ADULT

763.559.7050
3300 Fernbrook Lane N, #120
Plymouth, MN 55447

Please read this policy carefully, initial where indicated and sign.

Patient Name

Consent to Treat

- I consent to and authorize the health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my wellbeing. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test, performed at Psychology Consultation Specialists.
- Psychological services include consultation services regarding behavioral, developmental, or emotional concerns; which provides diagnostic clarification and treatment recommendations, and psychotherapy; which has been shown to have benefits in the reduction of feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees or assurances of what you will experience.
- I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting concern, to agree upon a treatment plan, and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them.
- I understand and acknowledge that Psychology Consultation Specialists may record medical and other information related to my treatment in electronic format and that such information will be used for payment purposes and to support healthcare operations.
- I understand, acknowledge and consent to the release of my personal health information for the purposes of treatment, payment and healthcare operations and as may otherwise be permitted by law.
- I specifically consent to the release by Psychology Consultation Specialists of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to: 1) my treating physicians and other healthcare providers and 2) any private health insurance plan, other governmental insurance program or other third-party payor identified to obtain payment for the treatment and services provided to me.
- Providers are often not immediately available to telephone. A message may be left with the front desk or on the provider's confidential voicemail. Every effort to return your call within a reasonable time is made during business hours. In the event of an emergency, contact your family physician, call 9-1-1 or proceed to the nearest emergency room.

Assignment of Benefits / Payment for Services

- There is a standard fee for professional services. Please ask for a fee schedule for details.
- Insurance will be billed for services. Insurance may or may not cover the services provided at Psychology Consultation Specialists. You are responsible for the amount due for any services not covered by your insurance plan. Payment can be made with a check, cash or credit card. Any checks returned to PCS are subject to an additional fee of $25.00. **I understand that I am financially responsible for all charges. (initial)**
- Insurance companies require a formal diagnosis with their claims. Diagnoses are technical terms that describe presenting concerns.
- Psychology Consultation Specialists (PCS) will bill your insurance company for your appointments. If you do not pay your deductible, co-pay or co-insurance at the time of your appointment, PCS will send you a billing statement. Any statement amount that you do not pay in full via the due date of that statement will be charged to the credit card on file. **It is our office policy to have a credit card number on file.**
- Past due accounts more than 60 days will be turned over to a collection service or small-claims court. If your account is sent to collections for non-payment, there will be a 33.33% fee added to the outstanding balance to cover incident collection costs.

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Important Notes

- **CANCELLATION POLICY:** Cancellations made with less than 24 hours' notice will be charged the full appointment fee ($200.00 - $250.00 / hour). This charge cannot be billed to your insurance policy. **(initial)**
- Financial arrangements between divorced parents must be handled independently of Psychology Consultation Specialists. Although court orders may assign responsibility for a child's healthcare expenses to one parent or another, we, as mental health providers, are not bound by the terms of such court orders. **Fees due on the day of an appointment must be collected at every visit regardless of who brings a child to the appointment. (initial if applicable)**
- If you become involved in litigation that requires Psychology Consultation Specialists participation (it is recommended that this is discussed fully *before* waiving the right to confidentiality), you will be responsible for the payment of professional time required even if Psychology Consultation Specialists is compelled to testify by another party. Our charge is $315.00 per hour for preparation and attendance at any legal proceeding.

By signing this consent for treatment, you fully understand the office policies and agree to abide by them. You acknowledge that you have been provided with a copy of the Notice of Privacy Practices, which describes uses, disclosures, and rights of your protected health information.

(Signature of Patient) Date (Signature of consenting party, if other than patient) Date

(Relationship to patient)

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AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

THIS WILL AUTHORIZE PSYCHOLOGY CONSULTATION SPECIALISTS, PLLC TO BOTH RELEASE TO, AND OBTAIN FROM:

_____ _____
(Name of primary care physician) (Address)

_____ _____
(City/state/zip) (Phone/fax)

THE FOLLOWING INFORMATION: **Applicable dates:** _____

Medical Records

Psychological Assessment

General Communication

Other:

The purpose of this information is for assessment and treatment planning. ***This authorization for release and exchange of confidential information is valid for one year from the signature date.***

FROM THE RECORDS OF:

_____ _____
(Name of patient) (Date of birth)

_____
(Address)

I understand:

- **That I have the right to inspect and copy the information disclosed.**
- **That I may cancel this authorization in writing at any time. Stopping this authorization will not apply to information that has already been released or disclosed.**
- **That this authorization shall expire without my express revocation one year from the date provided below.**
- **That any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.**
- **That my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided tome for the purpose of creating health information for a third party.**

_____ _____
(Signature of patient or parent/authorized legal guardian) Date

☐ **Checking this box signifies the decision of the patient or parent/authorized legal guardian to opt-out of signing this release of information.**

_____ _____ _____
Patient/Parent/Authorized legal guardian signature Date Provider initials

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AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

THIS WILL AUTHORIZE PSYCHOLOGY CONSULTATION SPECIALISTS, PLLC TO <u>BOTH</u> RELEASE TO, AND OBTAIN FROM:

(Name of provider) _____ (Address) _____

(City/state/zip) _____ (Phone/fax) _____

THE FOLLOWING INFORMATION: **Applicable dates:** _____

Medical Records	☐	School Records	☐
Speech/Language Evaluation	☐	Achievement Testing	☐
Psychological Assessment	☐	Teacher Rating Scales	☐
Psychiatric Evaluation	☐	504 Plan or IEP	☐
Physical Therapy	☐	Progress Reports	☐
Occupational Therapy	☐	Other:	☐
General Communication	☐		

The purpose of this information is for assessment and treatment planning. ***This authorization for release and exchange of confidential information is valid for one year from the signature date.***

FROM THE RECORDS OF:

(Name of patient) _____ (Date of birth) _____

(Address) _____

I understand:

- **That I have the right to inspect and copy the information disclosed.**
- **That I may cancel this authorization in writing at any time. Stopping this authorization will not apply to information that has already been released or disclosed.**
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(Signature of patient or parent/authorized legal guardian) _____ Date _____

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CHILD AND ADOLESCENT HISTORY FORM

I. General Information

Date

Child's Name/DOB:

Preferred Name:

Name of person completing form:

Relationship to Child:

Reason for referral; what are your primary concerns?

II. Parents & Family

Parent 1 Name:

Level of Education: Occupation: Employer:

Parent 2 Name:

Level of Education: Occupation: Employer:

Parents are: Married
Other parent(s)/stepparent(s)/caregivers:

Name: Relationship to child:

Name: Relationship to child:

People list all siblings or others living with the family:
Name Relationship Age

Siblings not living in the home:

Has your child experienced neglect or abuse? No

Has your child ever lost someone with whom s/he had a close relationship, (e.g. a parent, sibling, etc.)?

Have there been any recent stressful life events? (check all that apply)

- [ ] Divorce/Separation
- [ ] Financial Problems
- [ ] Substance Abuse
- [ ] Death of Family/Friend/Pet
- [ ] Marriage
- [ ] Change in Job Status
- [ ] Parenting disagreement
- [ ] Relationship conflict
- [ ] Sibling conflict
- [ ] Other:

III. Birth History

Mother's age at time of child's birth: Did mother receive prenatal care?

Medications taken during pregnancy? (please specify):

Were any of the following used during pregnancy? (including prior to knowledge of the pregnancy):

- [ ] Alcohol
- [ ] Marijuana
- [ ] Tobacco
- [ ] Methamphetamines
- [ ] Other Drugs

Please explain any complications during pregnancy, labor or delivery:

Method of delivery (vaginal, cesarean, forceps): Vaginal

Gestational age: Child's birth weight and length:

Any complications before the baby was taken home?

Any additional comments:

Any history of foster care/orphanage care/CPS involvement? No

If child is adopted: Age at adoption Contact with biological parents? No

Additional comments:

IV. Developmental History

Which hand does your child prefer: [ ] Right [ ] Left

Did your child ever have any motor coordination difficulties (e.g. frequent falling, awkwardness)? No

If yes, explain:

Did your child have any difficulty in learning to talk or have any speech problems? No

If yes, explain:

At what age was your child toilet trained? Day: Night:

Has your child had problems with the following? (check all that apply)

- [ ] Limited social interest
- [ ] Narrow range of interests
- [ ] Self-harm
- [ ] Withdrawn behavior
- [ ] Repetitive or odd behaviors
- [ ] Aggressive behaviors
- [ ] Tantrums
- [ ] Loss of developmental skills
- [ ] Shyness
- [ ] Poor eye contact
- [ ] Limited self-regulation
- [ ] Specific fears

Additional Comments:

V. Medical History

Does your child have or has s/he ever had any of the following (check all that apply):

	Age		Age
☐ Meningitis		☐ Loss of consciousness	
☐ Head injuries/Concussions		☐ High fever	
☐ Ear infections		☐ Heart Disease	
☐ Asthma		☐ Seizures	
☐ Other Illness:		☐ Other Illness:	

Please describe treatment given and any complications for illnesses/injuries indicated above:

Has your child ever been hospitalized? No At what age: For what:

Describe any hearing or vision problems:

List any previous surgeries, child's age, and length of hospitalization:

Other medical history:

Does your child frequently complain of or have problems with (check all that apply):

☐ Headache	☐ Weakness	☐ Fatigue
☐ Dizziness	☐ Nausea	☐ Wetting/soiling accidents
☐ Stomach aches	☐ Diarrhea	☐ Muscle tension

Current Medications:

For what has this medication been prescribed? Side Effects:

Who prescribes this medication?

Previous medications & dates taken:

Family Medical History: Has anyone in your child's family had any of the following?

	Yes	Who	Explain
Neurological Disease	☐		
Seizures (Epilepsy)	☐		
Psychiatric Problems	☐		
Emotional Problems	☐		
Alcoholism Problems	☐		
Substance Abuse Problems	☐		
Language Delays	☐		

Motor (physical) Delays ☐

Hyperactivity ☐

Learning Problems ☐

Autism Spectrum Disorders ☐

Similar problems to child ☐

VI. Evaluations & Services
For each category, please list any previous evaluations, examiners, dates, and results.

Health:
Pediatrician or Family Doctor:

Telephone: Fax:

Psychological/Neuropsychological:

Therapist/Examiner's Name: Title:

Telephone: Fax:

Dates of Last Evaluation/Sessions:

Occupational Therapy/ Physical Therapy/Speech & Language Therapy:

Clinic Name & Examiner's Name:

Date of Evaluation:

Therapy: Dates attended

Vision/Hearing:
Date of Last Examination:

Neurological:
Neurologist's Name:

Date of Last Examination:

Other:

VII. School
Name of Child's Current School:

Grade: Main Teacher or Counselor:

Has your child completed an evaluation through school (e.g., to qualify for special education)? No

Date:

Reason for Testing:

School History

	Name of School	Dates Attended	Concerns
Preschool			
Elementary			
Middle School/Junior High			
High School			

Has your child received any of the following (check all that apply):

	Dates or Grades	Additional Information
☐ Title 1		
☐ 504 Plan		
☐ IEP (special education)		
☐ Tutoring		

**Please provide a copy of any educational evaluations, 504 Plans or IEPs*

Check the word that best describes your child's grades throughout his/her school experience:

Superior

Has school reported current problems with (check all that apply):

☐ Reading	☐ Arithmetic	☐ Social Adjustment
☐ Writing	☐ Attention Span	☐ Following Directions
☐ Spelling	☐ Activity Level	☐ Other:

Thank you very much for completing this form. If you have additional comments or feel there is other information that would be valuable to us, please feel free to attach additional sheets.

During the past 7 days, how much has your child been bothered by any of the following problems?	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)	Item Score
Stomach, back, joint pain	◯	◯	◯	
Headache, stomachache, dizziness, shortness of breath	◯	◯	◯	
Constipation, diarrhea, nausea, low energy	◯	◯	◯	

During the past 7 days, my child…	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)	Item Score
had trouble staying asleep	◯	◯	◯	◯	◯	
had difficulty falling asleep	◯	◯	◯	◯	◯	
	Never (5)	**Rarely (4)**	**Sometimes (3)**	**Often (2)**	**Always (1)**	**Item Score**
got enough sleep	◯	◯	◯	◯	◯	

In the past 7 days...	Never (1)	Almost Never (2)	Sometimes (3)	Often (4)	Almost Always (5)	Item Score
My child felt mad.	◯	◯	◯	◯	◯	
My child was so angry he/she felt like yelling at somebody.	◯	◯	◯	◯	◯	
My child was so angry he/she felt like throwing something.	◯	◯	◯	◯	◯	
My child felt upset.	◯	◯	◯	◯	◯	
When my child got mad, he/she stayed mad.	◯	◯	◯	◯	◯	

Choose the response which best describes your child in the last 7 days:	Not at all (0)	Just a little (1)	Quite a bit (2)	Very Much (3)	Item Score
Fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.	◯	◯	◯	◯	
Has difficulty sustaining attention in tasks or play activities	◯	◯	◯	◯	
Does not seem to listen when spoken to directly.	◯	◯	◯	◯	
Does not follow through on instructions and fails to finish schoolwork, chores, or duties.	◯	◯	◯	◯	
Has difficulty organizing tasks and activities.	◯	◯	◯	◯	
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework)	◯	◯	◯	◯	
Loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)	◯	◯	◯	◯	
Is distracted by extraneous stimuli.	◯	◯	◯	◯	
Forgetful in daily activities (e.g., doing chores, running errands, returning calls, completing homework).	◯	◯	◯	◯	

Choose the response which best describes your child in the last 7 days:	Not at all (0)	Occasionally (1)	Often (2)	Very Often (3)	Item Score
Fidgets with hands or feet or squirms in seat.	◯	◯	◯	◯	
Leaves seat when he/she is supposed to stay in his/her seat.	◯	◯	◯	◯	
Runs about or climbs too much when he/she is supposed to stay seated.	◯	◯	◯	◯	
Has difficulty playing or starting quiet games.	◯	◯	◯	◯	

Is “on the go” or often acts as if “driven by a motor”.	○	○	○	○	
Talks too much.	○	○	○	○	
Blurts out answers before questions have been asked.	○	○	○	○	
Has difficulty waiting his/her turn.	○	○	○	○	
Interrupts or bothers others when they are talking or playing games.	○	○	○	○	

In the past 7 days, my child said he/she...	**Never (1)**	**Almost Never (2)**	**Sometimes (3)**	**Often (4)**	**Almost Always (5)**	**Item Score**
Could not stop feeling sad.	○	○	○	○	○	
Felt alone.	○	○	○	○	○	
Felt like he/she couldn’t do anything right.	○	○	○	○	○	
Felt lonely.	○	○	○	○	○	
Felt sad.	○	○	○	○	○	
Felt unhappy.	○	○	○	○	○	
Thought that his/her life was bad.	○	○	○	○	○	
Didn’t care about anything.	○	○	○	○	○	
Felt stressed.	○	○	○	○	○	
Felt too sad to eat.	○	○	○	○	○	
Wanted to be by himself/herself.	○	○	○	○	○	

In the past 7 days, my child said that he/she...	**Never (1)**	**Almost Never (2)**	**Sometimes (3)**	**Often (4)**	**Almost Always (5)**	**Item Score**
Felt like something awful might happen.	○	○	○	○	○	
Felt nervous.	○	○	○	○	○	
Felt scared.	○	○	○	○	○	
Felt worried.	○	○	○	○	○	
Worried about what could happen to him/her.	○	○	○	○	○	
Worried when he/she went to bed at night.	○	○	○	○	○	
Got scared really easy.	○	○	○	○	○	
Was afraid of going to school.	○	○	○	○	○	
Worried when he/she was at home.	○	○	○	○	○	
Worried when he/she was away from home.	○	○	○	○	○	

In the past 7 days and compared to others of the same age, how well do the following statements describe the behavior/feelings of your child?	**Not True (0)**	**Somewhat True (1)**	**Certainly True (2)**	**Item Score**
Is easily annoyed by others.	○	○	○	
Often loses his/her temper.	○	○	○	

Stays angry for a long time.				
Is angry most of the time.				
Gets angry frequently.				
Loses temper easily				
Overall irritability causes him/her problems.				
In the past 2 weeks, has your child...		**Yes**	**No**	**Don't Know**
Had an alcoholic beverage (beer, wine, liquor, etc.)				
Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?				
Used drugs like marijuana, cocaine or crack, ecstasy, hallucinogens, heroin, etc.				
Talked about wanting to kill himself/herself or about wanting to commit suicide				
Has he/she EVER tried to kill himself/herself?				

Parent Rating Scale –Child
(adapted from Fabiano et al., 2006)

1) How does your child's problems affect his or her interactions with playmates?

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

Regardless of whether or not this child is popular or unpopular, does he or she have a special, close "best friend" that he or she has kept for more than a few months? (Please check)

○ **YES** ○ **NO**

How do your child's problems affect his or her relationships with brothers or sisters? (If has no brothers or sisters, check here_____☐_____and skip to #2)

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

2) How do your child's problems affect his or her relationship with you (and your spouse/partner if present)?

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

3) How do your child's problems affect his or her academic progress at school?

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

4) How do your child's problems affect his or her self-esteem and/or emotional well-being?

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

5) How do your child's problems affect your family in general?

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

6) Please mark an "X" on the following line at the point that you believe reflects that <u>overall</u> severity of your child's problem in functioning and <u>overall</u> need for treatment.

No Problem (1)	(2)	(3)	(4)	(5)	Extreme Problem (6)
○	○	○	○	○	○

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Financial Policy

Please understand that payment of your bill is considered a part of your treatment for services.

Charges

- A fee schedule is available upon request
- An 18% discount is available to clients choosing not to use insurance and who pay in full at the time of service.

Payments

- All payments are due at the time of your appointment.
    - If services are submitted to insurance, we collect co-payment, co-insurance, and amounts toward deductibles on the day of your appointment.
    - If insurance is out-of-network, the full fee is due at the time of services. If payment is made by insurance, you will be reimbursed.
    - For self-pay patients, full payment is due at the time of service.
- The agreement with your insurance carrier is a contract between you and your insurance company. Billing insurance is not a guarantee of payment.
- If your insurance plan does not cover a service, a procedure, or a diagnosis, you are responsible for these charges. Educational services are not covered by health insurance.
- Payment can be made with a check, cash, Mastercard, Visa or Discover.
- We cannot guarantee that your HSA, HRA or Benefits credit card will work in our office.
- Please call ahead to make a payment arrangement for teenagers coming on their own.
- Please call our Billing Office at (763) 559-7050 to answer any questions.

Insurance

- Charges will be billed to your insurance carrier if we are provided current information.
- We attempt to gather benefit information. However, this does not guarantee payment.
- Please notify us prior to your next appointment if you have a change in insurance.

Divorce Agreements

- Financial arrangements between divorced parents must be handled independently of PCS. Although court orders may assign responsibility for a child's healthcare expenses to one parent or another, we are not bound by the terms of such court orders.
- Fees due on the day of an appointment must be collected at every visit.

Service/Finance Fees

- There is a $25 service charge for insufficient funds on debit cards and returned checks.
- Accounts unpaid after 30 days will be assessed a finance charge.
- Accounts with balances owing after 60 days will be referred for collection action.
- A credit card will be kept on file to avoid collection action.
- PCS shall be entitled to recover all costs and expenses incurred in seeking collection of charges, including court costs and attorney's fees.