Family Psychiatry & Psychology Associates, P.A.

INTAKE FORM

CONFIDENTIAL

Patient Information: ***Date:___________________***

Last Name: ________________________________ First: __________________________ MI: _____

Date of Birth: ________________ Age: ____ Sex:____ M ___ F SSN: _____________________

Mailing Address: ____

City/State: _____________________________________ Zip: ______________ Marital Status:____

Home: (____) _____ - _______ Work: (____) _____ - ________ Cell: (____) _____ - ________

Name of Person(s) Financially Responsible: ____

Relationship to Patient: ____

Address (if different than patient's): ____

City/State: ____ Zip: _______________________

Employer/School Information:

Name: ____

Occupation:____Grade:________

City/State:____

Education/Degrees: ____

Parent/Spouse's Information:

Name: ____ Phone: (____) _____ - __________

Relationship to patient: ____

Employer Name: ____________________________________ Phone: (____) _____ - __________

Address: ___________________________ City/State: _____________________ Zip: __________

Emergency Contact Information:

*In Case of Emergency, Contact ______________________Relationship to Patient:____________

Home: (____) _____ - _______ Work: (____) _____ - ________ Cell: (____) _____ - ________

Who can we thank for referring you here today?_____Internet _____Phone Book _____Friend
_____Doctor/Psychologist? (Name)____ _____Other

Medical History

Patient Name:____

Primary Care Physician:

Name of Practice: _________________________________ Doctor: __________________

Address: _______________________________________ Phone: (___) ____ - __________

Past Psychiatric and Medical Diagnoses (please give the year):

1) ____

2) ____

3) ____

Current Medications (Include dosage and frequency):

1) _________________________________ 2) ___________________________________

3) _________________________________ 4) ___________________________________

Known Allergies:

____

____

Severe Illness (childhood to present): ____

____

Previous Out/Inpatient Therapy (please specify which):____________________________

____

Stressors affecting you or your family in the past 1-2 years:

__Deaths
__Births
__Marriage
__Divorce
__Moving

__Job Change
__School
__Chronic Illness
__Separation
__Physical Abuse
__Other

__Sexual Abuse
__Broken Relationship
__Unwanted Pregnancy
__Substance Abuse
__Medical

Presenting Problem/Reason for Visit*:*____

____

____

FAMILY PSYCHIATRY & PSYCHOLOGY ASSOCIATES, P.A.
FINANCIAL POLICY

APPOINTMENTS

The keeping of regular appointments is crucial to successful therapy. As schedule permits, we will work out a most convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you.

_______Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at the rate of the reserved session. You will be billed directly for this time.

PAYMENT OF FEES

_______FPPA does not participate with any insurance plan nor do we file on your behalf. We will provide you with all necessary paperwork to assist you in filing with your insurance company. Payment to FPPA is to be made in full at the time of service. We accept cash, check, MasterCard/Visa, and Discover. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

_______I am not a Medicare or Medicaid patient.
By signing this, you are informing our office that you are not a Medicare or Medicaid patient. If you are a Medicare or Medicaid patient, please inform our front desk staff.

REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS

_______Any reports or professional consultations involving time beyond that of the regular scheduled session will be billed at a pro-rated charge for the professional time involved.
_______We will charge for telephone, email and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should your provider deem it appropriate.
_______Psychological Testing results may not be released until the testing bill is paid in full.

CONSENT TO RELEASE OF INFORMATION

Patient agrees that his/her clinician may share information with other professional staff at Family Psychiatry and Psychology Associates, P.A. (FPPA) with regard to his/her case in order to better provide quality treatment. This information will be kept strictly confidential and remain in the confines of FPPA only.

READ CAREFULLY AND SIGN

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

____

Signature of Patient/Responsible Party Date

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclosed your medical records only for each of the following purposes:

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friend, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you

with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information at the address listed at the bottom of the page.

For more information about HIPPA or to file a complaint:

The U.S. Dept. of Health & Human Services
Office of Civil Right
200 Independence Avenue, S.W.
Washington, D.C. 20201

Patient name: ______________________________ D.O.B.____________________

Social Security Number: ____________________________________

PATIENT ACKNOWLEDGEMENT

I understand that the patient's health information is private and confidential. I understand that Family Psychiatry and Psychology Associates, P. A. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Family Psychiatry and Psychology Associates, P.A. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there are not other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)

Family Psychiatry and Psychology Associates, P. A. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices". If I ask, Family Psychiatry and Psychology Associates, P.A. will provide me with the most current "Notice of Privacy Practices".

Within the Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records: restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Family Psychiatry and Psychology Associates, P.A. has established procedures which help them meet their obligations to patients. Their procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist Family Psychiatry and Psychology Associates, P. A. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Family Psychiatry and Psychology Associates, P.A. "Notice of Privacy Practices".

____

Patient or legally authorized individual signature Date Time

____

Relationship to patient if signed by anyone other than the patient

Family Psychiatry & Psychology Associates, P.A.

ABBREVIATED ADHD SYMPTOM CHECKLIST

CHILD'S NAME: ______________________________ DATE: ____________________

PERSON COMPLETING FORM: ____________________ PARENT: ______ TEACHER: ____

DIRECTIONS: INDICATE THE DEGREE TO WHICH EACH ITEM BELOW IS A PROBLEM BY CIRCLING THE CORESPONDING NUMBER. PLEASE RESPOND TO ALL ITEMS.

	NEVER	SOMETIMES	OFTEN	VERY OFTEN
1. DOESN'T PAY ATTENTION TO DETAILS; MAKES CARELESS MISTAKES	0	1	2	3
2. DIFFICULTY PAYING ATTENTION	0	1	2	3
3. DOES NOT SEEM TO LISTEN	0	1	2	3
4. DIFFICULTY FOLLOWING INSTRUCTIONS; DOES NOT FINISH THINGS	0	1	2	3
5. DIFFICULTY GETTING ORGANIZED	0	1	2	3
6. AVOIDS DOING THINGS THAT REQUIRE A LOT OF MENTAL EFFORT	0	1	2	3
7. LOSES THINGS	0	1	2	3
8. EASILY DISTRACTED	0	1	2	3
9. FORGETFUL	0	1	2	3
10. FIDGETS WITH HANDS OR FEET; SQUIRMS IN SEAT	0	1	2	3
11. DIFFICULTY REMAINING SEATED	0	1	2	3
12. RUNS ABOUT OR CLIMBS ON THINGS	0	1	2	3
13. DIFFICULTY PLAYING QUIETLY	0	1	2	3
14. "ON THE GO"; ACTS AS IF "DRIVEN BY A MOTOR"	0	1	2	3
15. TALKS EXCESSIVELY	0	1	2	3
16. BLURTS OUT ANSWERS TO QUESTIONS	0	1	2	3
17. DIFFICULTY AWAITNG TURN	0	1	2	3
18. INTERRUPTS OTHERS OR BUTTS INTO THEIR ACTIVITIES	0	1	2	3

1400 Crescent Green, Suite 120, Cary, North Carolina 27518
Tel: 919-233-4131 Fax: 919-233-4168

Family Psychiatry and Psychology Associates, P.A.

1400 Crescent Green, Suite 120, Cary, NC 27518 Office: (919) 233-4131 Fax: (919) 233-4168

Seth E. Tabb, M.D. Amanda S. Dorn, M.D. Jennifer D. Siddle, M.D. Lisa Hayutin, Ph.D.
Sheryll A. Daniel, Ph.D.

Release of Information

I, _____________________________________, consent to allow all clinicians of Family Psychiatry and Psychology Associates, P.A. listed above to release and/or exchange information regarding

_______________________________. ____________
(Client) (Date of Birth)

This information will include:

___Psychiatric Records ___Psychological Testing
___Procedures ___Therapy Notes
___Medical Records ___Laboratory Work
___Educational Records ___Other _________________
___Discharge Summary ___All of the above

Information can be shared with the following people/agencies (please include address):

____

____

____

I understand that this information will be used in the client's best interests to benefit current psychiatric and psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of FPPA not to release those materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place.

Signature: ____________________________Witness: __________________________

Relationship to Client: __________________Date: _________________

This consent is valid until _____________________. If I fail to specify an expiration date, this authorization will automatically expire 12 months from the date of signature.

Rescind Consent: I hereby rescind the prior consent granted to Family Psychiatry and Psychology Associates, P.A. to release and/or discuss any information with the individual(s)/agencies listed above.

Signature:_______________________________________ Date:________________

Family Psychiatry and Psychology Associates, P.A.

1400 Crescent Green, Suite 120, Cary, NC 27518 Office: (919) 233-4131 Fax: (919) 233-4168

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Sheryll A. Daniel, Ph.D.

SAMPLE Release of Information

I, ________*Person signing this form*__________, consent to allow all clinicians of Family Psychiatry and Psychology Associates, P.A. listed above to release and/or exchange information regarding ____*Patient Name*__________________. _*Date of Birth*_
(Client) (Date of Birth)

This information will include: ***(Check appropriate boxes for types of information to be shared)***

___Psychiatric Records
___Procedures
___Medical Records
___Educational Records
___Discharge Summary
___Psychological Testing
___Therapy Notes
___Laboratory Work
___Other _________________
___All of the above

Information can be shared with the following people/agencies (please include address):
____**Names, addresses and/or phone number(s) of people with whom information may be shared**
____
____

I understand that this information will be used in the client's best interests to benefit current psychiatric and psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of FPPA not to release those materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place.

Signature: ____*Sign here*_______________ Witness: __*Please have witness sign here*__

Relationship to Client: _*Relationship to patient of person who signs*__Date: __*Date of signature*_____

This consent is valid until ____*Optional*________. If I fail to specify an expiration date, this authorization will automatically expire 12 months from the date of signature.

Rescind Consent: I hereby rescind the prior consent granted to Family Psychiatry and Psychology Associates, P.A. to release and/or discuss any information with the individual(s)/agencies listed above.

Signature:____ Date:________________