Child-Adolescent Questionnaire

The Meridian Group of Chesterfield
MeridianHelp.com
10109 Krause Rd., Suite 100
Chesterfield, VA 23832-6501
Office: (804) 751-8644
Fax: (804) 751-0648

_____ Clinician:
Time and Date of First Appointment

___ John Dwyer, PhD
___ David Epstein, Psy
___ Melissa Findlay, LCSW
___ Jill Sexton-Newton, LCSW
___ Elizabeth Novak, LCSW

In order to determine the best approach for helping your child, it would help to have information about your family and your child's problems. Therefore, it is requested that the parent(s) or guardian(s) complete this questionnaire as completely as possible at or before the first appointment. Don't worry if you are unable to recall all information requested. Good guesses or general answers are acceptable.

Name of Child: _____ Gender: M F
first middle initial last

Date of Birth: _____ Age: _____ Grade: _____ School: _____

Mother: _____ Age: _____ Education: _____ Occupation: _____

Address: _____
street city state zip

Primary Phone: _____ (cell / home / work)
Please list only phone numbers your clinician may call

Second Phone Contact: _____ (cell / home / work)

Email: _____ Place of Employment: _____
By providing email you give consent for email communication. May not consent for someone else

Father: _____ Age: _____ Education: _____ Occupation: _____

Address: _____
street city state zip

Primary Phone: _____ (cell / home / work)
Please list only phone numbers your clinician may call

Second Phone Contact: _____ (cell / home / work)

Email: _____ Place of Employment: _____
By providing email you give consent for email communication. May not consent for someone else

With whom does the child live?: _____ If not living with a parent, caregiver information:

Name: _____ Address: _____
street city state zip

Relationship _____ Primary Phone: _____ Email: _____
e.g. grandparent, foster parent, etc. Please list only phone numbers your clinician may call. Providing email gives consent for email use

Who referred you to our office:?: _____

Primary Care Physician: _____ Insurance Company: _____

Please make sure that you have called your insurance company prior to the first visit to confirm your mental health coverage and to obtain authorization of services, if needed. The telephone number is usually listed on your insurance card.

Current Medications:_____ Date of Last Physical Exam:_____

Previous Mental Health Treatment, Including Medications (When and by whom):_____

_____

Name(s) of Stepfather and/or Stepmother:_____

Brothers & Sisters (Please note if half and step-sibling, and who is the parent):

Name	Gender	Age	Problems (If any)

Information on the Child to be Treated:

1. As completely as possible, please describe the problems you feel your child is experiencing, or the reason you are bringing your child for services:

2. Does your child have the following problems (please check all that apply)? Has he/she had them in the past (mark past behaviors not currently a problem with a P)?

____ Depression
____ Crying spells
____ Loneliness
____ Low self-esteem
____ Irritable mood
____ Feeling hopeless
____ Feeling worthless
____ Excessive guilt
____ Overly self-conscious
____ Loss of interest in pleasurable activities
____ Indecisive
____ Anxiety
____ Panic Attacks
____ Fear of physical harm
____ Other fears/phobias
____ Overly dependent for age
____ Obsessive or Compulvie
____ Problems making or keeping friends
____ Hallucinations
____ Harm or injury to self
____ Thinking/Talking of death or suicide
____ Suicide attempt(s)
____ Excessive worry
____ Shy/timid
____ Bullied / Picked on by peers

____ Anger
____ Defiance of Rules
____ Bed Temper
____ Frequent Swearing
____ Spiteful or vindictive
____ Frequent fights
____ Difficult to control
____ Lying
____ Argumentative
____ Conflict with parent(s)
____ Distant from parent(s)
____ Stealing
____ Problems with authority
____ Destructive
____ Fire setting
____ Poor judgment
____ Harming other children
____ Harming animals
____ Verbal aggression toward peers
____ Verbal aggression toward siblings
____ Physical aggression toward peers
____ Physical aggression toward siblings
____ Frequent nightmares

___ Poor Attention or concentration
____ Impulsive
____ Overactive
____ Distractible
____ Low academic motivation
____ Homework problems
____ Achieving below potential
____ Refuses to go to school
____ Frequent detentions
____ School suspensions

____ Speech/Language problems
____ Problems with reading
____ Problems with math
____ Problems with writing
____ Problems understanding written instructions
____ Problems understanding verbal instructions

___ Smoking
___ Alcohol Use
___ Legal charges
___ Drug Use (Specify):

____ Physical abuse/ neglect
____ History of sex abuse
____ Bad home conditions
____ Inappropriate sexual behavior or interests

____ Eating Problems
____ Underweight
____ Overweight
____ Thumb sucking after age 3
____ Problems getting or staying sleep
____ Bedwetting after age 4
____ Soiling pants

Other problems or unusual behaviors:

3. What do you think may be causing your child's problem(s)?:

4. Describe the course of pregnancy (complications, etc.):

5. Describe the delivery (anesthesia, cesarean, complications):

6. Describe the infant's condition at birth:

7. What was your family's situation surrounding the time of your child's birth?:

8. Have there been any medical problems or procedures beyond normal childhood illnesses or accidents? If so, please describe (e.g., hospitalizations, broken bones, tubes in ears, etc.):

9. Does your child have allergies or asthma? If so, please describe:

10. At approximately what age did your child do the following? (These may be difficult to remember; estimates are acceptable.)

____ Sit up	____ Walked alone	____ Started preschool
____ Spoke first Words	____ Spoke in sentences	____ Began puberty
	____ Toilet trained day	____ Toilet trained night

11. Has your child ever received or been considered for or evaluated for special education services? If yes, what type of services and for what grades?:

12. How does your child currently do in school? (academic & behavior):

13. Briefly describe your child's school history including academic work & behavior (summarize across grades if academics and behavior did not change):

Kindergarten:	1st Grade:	2nd Grade:
3rd Grade:	4th Grade:	5th Grade:
Middle School:	High School:	

14. How does your child get along with peers and siblings?:

15. How would you describe your child's personality?:

16. What are your child's strengths and interests?:

17. Has either parent lived apart from the child for any extended period of time? If so, when and for how long? If parents are separated or divorced, what is the typical visitation situation:

18. Describe any past traumatic or stressful psychological events experienced by your child such as abuse, death of close friend or family member, death of pet, etc.:

19. Has any member of the extended family (parents, grandparents, uncles, aunts, cousins) experienced any emotional or behavioral problems? Did they receive any treatment for these problems?

20. Alcohol use by mother: father: step-parent:

21. Alcohol or substance abuse by child: No Yes (if yes, please describe):

22. List family moves and their dates since birth of this child:

23. Previous marriages (specify father/mother):

24. How would you describe your marriage or relationship with spouse, partner, boyfriend or girlfriend ? On what issues do you disagree?:

25. What type of discipline do you use for your child and how does it work?:

26. How have you explained to your child that you are bringing him/ her to see a therapist?:

26. Additional comments or remarks:

_____ _____ _____

Signature of respondent Relationship to Child Date

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Office Policies
Children & Adolescents

Who Will Be Responsible for Payment of This Account?

Name:_____ Phone#:_____ SSN#:_____

Street Address (if different from above):_____
street city state zip

Signature:_____ Date:_____
Cannot sign for someone else.

Agreement to allow direct insurance payment

Please note that most insurance companies provide coverage for mental health services. If you have insurance, your portion of payment for each session may be the copay or deductible specified by your insurance company.

I authorize medical payments from:_____
Insurance Company(s)

_____
Name of Parent/Guardian Holding Insurance Their Date of Birth Insurance ID Their SSN

to The Meridian Group and/or specific clinician seen for services rendered.

Employer of Insured:_____ Your Co-pay for each session (if known): _____

Do you have a deductible?: ___No ___ Unsure ___Yes If yes, amount and start date: _____

Does your insurance require pre-authorization?: ___Yes ___ No ___ Unsure

If yes, have you called your insurance company to have services approved?: ___ Yes __No

If authorization obtained, authorization number: _____ Number of Sessions: _____

Signature: _____ Date: _____

Patient-Clinician Agreement: Parent

Thank you very much for choosing the Meridian Group for mental health services. We understand that the decision to seek treatment is not always an easy one. Please be assured that we will provide individualized, quality services that will actively involve you in your child's treatment. Should you have any questions or concerns about any aspect of your treatment or office procedures, please do not hesitate to talk to your clinician.

Your clinician is associated with the Meridian Group of Chesterfield, which was formed to more fully serve the community by offering a full range of mental health and substance abuse services. However, each individual clinician maintains their own independent practice. Record keeping and confidential clinical information is maintained separately by each clinician and therefore your child's individual clinician is solely responsible for treatment. Your clinician may occasionally find it helpful to consult other health and mental health professionals about you. During a consultation, HIPAA regulations are always observed to ensure that all information remains confidential. The other professionals are also legally bound to keep the information confidential. If your clinician is out of town or otherwise not available, another clinician of the Meridian Group of Chesterfield may be asked to cover for emergencies. Any information given to them about you will be kept confidential.

In Case of Emergency: If you believe there is an emergency that could result in injury to your child, yourself or another, call 911. For other emergencies, during office hours, call our main number, 751-8644 and press "0" and the office manager will contact your clinician. Outside of office hours, call our main number and follow the prompts for emergency contact after hours. You will be given instructions on how to contact the answering service, who will contact the on-call clinician, who will return your call promptly. In the unlikely event that you cannot reach the clinician on call, contact your local Community Mental Health Crisis Line. For any medical emergencies, including problems with medication, your prescribing physician should be contacted.

Psychotherapy: Psychotherapy is not easily described in general statements. It is a collaborative process between you and your child's clinician. There are many different methods your clinician may use to deal with the problems that you hope to address for your child. Psychotherapy is not like a medical doctor's visit, in that it requires an active effort on your part. In order for the therapy to be most successful, you will be actively involved in working toward treatment goals both during your child's sessions and at home for your child. Please inform your clinician of any problems you anticipate in following recommendations.

Psychotherapy can have benefits and risks. Since therapy often involves discussion of unpleasant aspects of your child's emotions and behaviors, you or your child may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what your child will experience. If you have questions about procedures, please feel free to discuss them whenever they arise.

Psychological Testing: Psychological testing involves standardized measures that may include measures of attention, intelligence, achievement, emotions, personality, or other psychological factors. You will be provided with an explanation of the purpose of testing and testing procedures and will have access to the results. If the testing referral was made by an outside referral source, please be sure you understand how the results will be used and how they will affect you and your child.

HIPAA and Patient Rights and Responsibilities: Clinicians of the Meridian Group believe that intervention is most effective when you are aware of your rights and responsibilities. We are also committed to protecting your confidentiality and privacy. The HIPAA Notice of Privacy Practices and Policies given to you (blue form) tells you about the ways your clinician may use and disclose the protected health information about you. It explains the limits of confidentiality and describes the clinician's obligations and your rights regarding the use and disclosure of information.

Your signature below indicates that you have read this Client-Clinician Agreement and agree to its terms. It also serves to acknowledge that you have received the HIPAA Notice described above. Concerning all of these forms and notices, please feel free to bring up any questions or points of clarification with your clinician at any time.

Signature: _____ Date: _____

Payment Policies

1. Insurance companies will generally reimburse for services at the same level as other medical visits. We will file your insurance claims as a courtesy to you. Please be aware, however, that you, not the insurance company, are ultimately responsible for payment of all charges. By agreeing to these Payment Policies, you agree to be responsible for paying for all services provided. Please have your insurance card available on your first visit to verify coverage. You should also determine if there is an annual deductible before your first visit. Deductibles usually apply at the beginning of your benefit year. **Your co-pays and deductible payments must be made at the time of each visit.**

2. If your account is unpaid for more than 45 days and arrangements for payment have not been agreed upon, then the option of using legal means may be used to secure payment. This may involve hiring a collection agency, attorney, or going through small claims court, which will require the disclosure of otherwise confidential information. The cost of that service, up to 33.33% of the amount owed, will be added to your balance. In most collection situations the only information released regarding a patient's treatment is his/her name (and parents' names for children), address, phone numbers, the nature of services provided, payment history, and the amount due.

3. In some cases another party may be legally responsible for payment of medical bills. However, responsibility for payment of fees falls to the individual, parent or guardian who arranged for services.

4. Insurance companies do not reimburse for missed appointments. Therefore, there will be a $50.00 charge for missed appointments unless the clinician or the receptionist is notified at least 24 hours prior to the appointment. This charge may be waived in the event of emergency or illness. There is also a $50.00 returned check fee for checks written with insufficient funds If records are requested, there is a copying fee of $.50 per page plus mailing costs.

5. If consultation with the legal system is requested or required as a result of services provided to you or your child, you will be expected to assume the expenses associated with the time involved. Court appearance cost includes travel, preparation, and total time spent at the courthouse. It also includes time lost at the office if the court hearing is canceled on short notice. Court related activities are charged at a minimum of $750 which includes the first 3 hours of time. There is an additional charge of $250 per hour when more than three hours is required. Court appearance for one-half day, four hours or less, is $750. A full day court appearance, more than four hours, is $1500. An initial fee of $750 is due fourteen (14) days in advance of the court date. Payment is due by you regardless of who initiates a court appearance. For contact with others involved in legal proceedings (e.g.: attorneys, CASA workers, guardians ad litem, social services, court evaluators, judges) the cost is $250 per hour, billed by the quarter hour. Payments for letters, reports, treatment summaries, or other information provided to third parties will also be assessed at $250 that will be due prior to the release of the information. Brief contact with those involved in legal proceedings will not result in a charge. If records are requested, there is a copying fee of $.50 per page plus mailing costs.

6. If you wish to seek third-party reimbursement for services, your contract with them gives them the right to request information for determination of medical necessity and payment. Typical information supplied includes dates of treatment, type of treatment, and nature of your problem or illness (diagnosis). Some insurance companies may also require more detailed information such as treatment plans and periodic chart reviews. Information provided to them will become part of the insurance company file and your clinician will not have control over their use of the information. They are, however, bound by HIPAA, state and federal law to handle the information with your confidentiality in mind. Your signature below provides authorization for me to disclose this information. Please refer to your insurance contract for their specific information requirements.

7. If you are self-pay and/or uninsured, you will be informed of a Good Faith Estimate of the cost of services. Your clinician will inform you of the estimated cost of services prior to receiving treatment and if those costs change. You will receive a confirmation of costs both orally and in writing. The estimate does not additional charges due to complications or changes in circumstances. The Good Faith Estimate only pertains to those who are self-pay and/or uninsured. If you are using insurance, payments are determined by your insurance coverage.

I have read this form explaining payment policies and agree to abide by conditions specified.

Signature: _____ **Date: _____**

The Meridian Group of Chesterfield

Authorization for the release of confidential information
Primary Care Physician

It is often helpful to inform your primary care physician (PCP) that you are involved in psychological treatment. Your PCP is typically your family physician or pediatrician. While most insurance does not require an authorization from the PCP for you or your child to receive counseling, you may want your PCP informed that you are receiving services. However, you are under no obligation to have any information released. You or your child's treatment will not be affected in any way if you decide not to authorize the release of information.

If you authorize information released to your PCP, a brief letter or phone call may be made to your PCP informing him or her that you or your child have started receiving services and the reasons you have come for treatment. Ongoing contact may occur as needed.

Patient's Name: _____

Primary Care Physician (PCP): _____

Please sign A or B below, <u>but not both</u>:

A: I hereby **<u>give</u>** my authorization to inform my primary care physician that I or my child is receiving treatment and the reasons for treatment. This release is valid for one year unless noted otherwise.

I have the right to revoke this authorization at any time by informing the above-named therapist in writing. However my revocation will not be effective to the extent that my clinician has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Please understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Representative*: _____ Date: _____

B: I hereby **<u>decline</u>** authorization to inform my primary care physician that I or my child is receiving services (no information will be released to your primary care physician):

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Representative*: _____ Date: _____

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* If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. This information is confidential and is protected by Federal law. A photocopy of this completed form is considered as valid as the original.