



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):

<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Problems</u> (If any)
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### 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)?

<input type="checkbox"/> Depression	<input type="checkbox"/> Anger	<input type="checkbox"/> Poor Attention or concentration	<input type="checkbox"/> Smoking
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Defiance of Rules	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Bed Temper	<input type="checkbox"/> Overactive	<input type="checkbox"/> Legal charges
<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Frequent Swearing	<input type="checkbox"/> Distractible	<input type="checkbox"/> Drug Use (Specify):
<input type="checkbox"/> Irritable mood	<input type="checkbox"/> Spiteful or vindictive	<input type="checkbox"/> Low academic motivation	<input type="checkbox"/> Physical abuse/neglect
<input type="checkbox"/> Feeling hopeless	<input type="checkbox"/> Frequent fights	<input type="checkbox"/> Homework problems	<input type="checkbox"/> History of sex abuse
<input type="checkbox"/> Feeling worthless	<input type="checkbox"/> Difficult to control	<input type="checkbox"/> Achieving below potential	<input type="checkbox"/> Bad home conditions
<input type="checkbox"/> Excessive guilt	<input type="checkbox"/> Lying	<input type="checkbox"/> Refuses to go to school	<input type="checkbox"/> Inappropriate sexual behavior or interests
<input type="checkbox"/> Overly self-conscious	<input type="checkbox"/> Argumentative	<input type="checkbox"/> Frequent detentions	
<input type="checkbox"/> Loss of interest in pleasurable activities	<input type="checkbox"/> Conflict with parent(s)	<input type="checkbox"/> School suspensions	
<input type="checkbox"/> Indecisive	<input type="checkbox"/> Distant from parent(s)		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stealing	<input type="checkbox"/> Speech/Language problems	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Problems with authority	<input type="checkbox"/> Problems with reading	<input type="checkbox"/> Underweight
<input type="checkbox"/> Fear of physical harm	<input type="checkbox"/> Destructive	<input type="checkbox"/> Problems with math	<input type="checkbox"/> Overweight
<input type="checkbox"/> Other fears/phobias	<input type="checkbox"/> Fire setting	<input type="checkbox"/> Problems with writing	<input type="checkbox"/> Thumb sucking after age 3
<input type="checkbox"/> Overly dependent for age	<input type="checkbox"/> Poor judgment	<input type="checkbox"/> Problems understanding written instructions	<input type="checkbox"/> Problems getting or staying sleep
<input type="checkbox"/> Obsessive or Compulsive	<input type="checkbox"/> Harming other children	<input type="checkbox"/> Problems understanding verbal instructions	<input type="checkbox"/> Bedwetting after age 4
<input type="checkbox"/> Problems making or keeping friends	<input type="checkbox"/> Harming animals		<input type="checkbox"/> Soiling pants
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Verbal aggression toward peers		
<input type="checkbox"/> Harm or injury to self	<input type="checkbox"/> Verbal aggression toward siblings		
<input type="checkbox"/> Thinking/Talking of death or suicide	<input type="checkbox"/> Physical aggression toward peers		
<input type="checkbox"/> Suicide attempt(s)	<input type="checkbox"/> Physical aggression toward siblings		
<input type="checkbox"/> Excessive worry	<input type="checkbox"/> Frequent nightmares		
<input type="checkbox"/> Shy/timid		Other problems or unusual behaviors:	
<input type="checkbox"/> Bullied / Picked on by peers			

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.)
 

<input type="checkbox"/> Sit up	<input type="checkbox"/> Walked alone	<input type="checkbox"/> Started preschool
<input type="checkbox"/> Spoke first Words	<input type="checkbox"/> Spoke in sentences	<input type="checkbox"/> Began puberty
	<input type="checkbox"/> Toilet trained day	<input type="checkbox"/> 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:	1 <sup>st</sup> Grade:	2 <sup>nd</sup> Grade:
3 <sup>rd</sup> Grade:	4 <sup>th</sup> Grade:	5 <sup>th</sup> 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:

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 Signature of respondent

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 Relationship to Child

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 Date



# Office Policies Children & Adolescents

MeridianHelp.com

10109 Krause Rd., Suite 100  
Chesterfield, VA 23832-6501

Office: (804) 751-8644  
Fax: (804) 751-0648

### List of Charges:

Initial Diagnostic Evaluation Psychologist.....\$150  
 Psychotherapy Psychologist: 45 Minutes.....\$130  
 Initial Diagnostic Evaluation Clinical Social Worker....\$140  
 Psychotherapy Clinical Social Worker: 45 Minutes.....\$120  
 Co-parenting (per hour).....\$150  
 Initial Diagnostic Evaluation Professional Counselor....\$140  
 Court Appearance.....See Payment Policy  
 Psychotherapy Professional Counselor: 45 Minutes.....\$120  
 Group Therapy: 1 to 2 hours.....Variable  
 Letters, treatment summaries, and report to third parties (e.g., courts, attorneys, schools).....\$50 and up  
 Psychological Evaluations:.....\$150 hr (billed hourly, including interpretation and report)

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

Consultations (per hour).....\$150

### 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

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 insure 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.

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

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## 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, but not both:

**A:** I hereby give 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 decline 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: \_\_\_\_\_

\* 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.