Registration Form
Psychology Consultation Specialists

Date_____

Child's Information

Patient Name (Print)_____**Date of Birth** _____
Last Name First Name Initial

Street Address_____Home Phone:_____

City_____State_____ZIP_____ **Gender:** Female Male Age: _____

Parent 1 Name: _____ Phone(s) Cell Work _____

Parent 2 Name:_____ Phone(s) Cell Work _____

Parent 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.

Consent to Treat

- 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.
- Providers are often not immediately available by 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. 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.
- Any checks returned to the office are subject to an additional fee of $25.00.
- Past due accounts more than 60 days will be turned over to a collection service or small-claims court.
- 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.
- 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 collections costs.

Important Notes

- CANCELLATION POLICY: Cancellations made with less than 24 hours' notice will be charged the full appointment fee. 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) (Address)

_____ _____ _____
(city/state/zip) (Date of birth) (phone number)

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 to me 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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_____ _____
(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	_____		

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FROM THE RECORDS OF:

_____ _____
(Name of patient) (Address)

_____ _____ _____
(city/state/zip) (Date of birth) (phone number)

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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 ___ Never Married ___ Separated ___ Divorced ___ Living together ___ Other_____
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? Yes _____ No _____ Suspected _____ Unknown _____

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
	Disagreement about parenting		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): _____

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? _____

If child is adopted: Age at adoption _____ Contact with biological parents? _____

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)?

If yes, explain: _____

Did your child have any difficulty in learning to talk or have any speech problems?

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? _____ 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:

Date of Evaluation: _____

Clinic Name & Examiner's Name: _____

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)?

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

_____ Superior _____ Above Average _____ Average _____ Below Average _____ Failing

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.

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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.					

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)	Not at all (0)
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					Extreme Problem
1	2	3	4	5	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 circle)

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					Extreme Problem
1	2	3	4	5	6

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

No Problem					Extreme Problem
1	2	3	4	5	6

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

No Problem					Extreme Problem
1	2	3	4	5	6

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

No Problem					Extreme Problem
1	2	3	4	5	6

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

No Problem					Extreme Problem
1	2	3	4	5	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					Extreme Problem
1	2	3	4	5	6