

Child/Adolescent Intake Form
Clinton S. Felker, Ph.D Psychological Services

Name_____ Date_____

Age_____ Date of Birth_____ School & Grade_____

Address_____

City, State, Zip_____ Bill to this Address? Yes No

If no, Alternate Address_____

Phone(s) Home_____ Cell_____ Work_____

Any Numbers You DO NOT want voice mail or text messages left?

Home Cell Work

Email_____

OK to use for appointments? Yes No

Mother's Name_____ Education_____

Father's Name_____ Education_____

Relationship Status_____ How Long Together?_____

Partner if different than above_____ Relationship_____

Mother's Employer_____ Position_____ Length_____

Father's Employer_____ Position_____ Length_____

Names and ages of children or others in home_____

Emergency Contact_____ Phone_____

Who referred you to Dr. Felker?_____

Who will pay deductibles, co-pay, self-pay? _____

Primary Insurance _____

Policy Holder _____ Relationship _____

SSN if different from above _____ D.O.B. _____

Secondary Insurance _____

Policy Holder _____ Relationship _____

SSN if different from above _____ D.O.B. _____

If using insurance for services, please sign below. _____

I hereby grant Dr. Felker and his billing service authorization to release any Protected Health Information (PHI) to my insurance company necessary for the purpose of billing. This typically includes information such as identification, diagnosis, and date and type of service but NOT Psychotherapy Notes which can only be released by my signed release. I authorize my insurance company to send payment directly to Dr. Felker. I authorize Dr. Felker to release claim forms and supporting documentation to the Ohio Department of Insurance if Dr. Felker files a claim against my insurance company under the Ohio Prompt Payment Law. I agree that a photocopy of this authorization shall be as valid as the original.

Parent or Guardian Signature Date

Child/Adolescent Problem Checklist

Name _____

	None	Slight	Mild	Moderate	Severe	Had in Problem the Past
How often (days per two weeks)	0	1-2	4-6	7-10	11-14	
Hearing things (e.g., voices) when no one is around.	0	1	2	3	4	_____
Confused thinking.	0	1	2	3	4	_____
Periods of little sleep but still has plenty of energy.	0	1	2	3	4	_____
Starting many projects, doing risky things.	0	1	2	3	4	_____
Staying awake for long periods then crashing.	0	1	2	3	4	_____
Abrupt mood swings with or without reason.	0	1	2	3	4	_____
Self-harm thoughts or actions	0	1	2	3	4	_____
Little or no pleasure in doing things.	0	1	2	3	4	_____
Frequent crying.	0	1	2	3	4	_____
Withdrawing from others and activities.	0	1	2	3	4	_____
Appearing down, depressed, hopeless.	0	1	2	3	4	_____
Frequently feeling tired.	0	1	2	3	4	_____
Feeling irritated, grouchy, or angry often.	0	1	2	3	4	_____
Frequent arguments with others.	0	1	2	3	4	_____
Frequently defiant.	0	1	2	3	4	_____
Throwing or Breaking things.	0	1	2	3	4	_____
Loses temper, physically acts out, hurts others.	0	1	2	3	4	_____
Excessive worrying, nervous about activities.	0	1	2	3	4	_____
Separation anxiety.	0	1	2	3	4	_____
Overly shy.	0	1	2	3	4	_____
Feeling panic or frightened.	0	1	2	3	4	_____
Feeling driven to repeat actions or mental acts.	0	1	2	3	4	_____
Ideas about doing bad things/bad things happening.	0	1	2	3	4	_____
Repeated unpleasant thoughts, urges, or images.	0	1	2	3	4	_____
Can't stop remembering unpleasant past events.	0	1	2	3	4	_____
Complains of aches, upset stomach, headache.	0	1	2	3	4	_____
Problems with sleep quality or amount.	0	1	2	3	4	_____
Nightmares, night terrors, sleep walking	0	1	2	3	4	_____
Problems with diet, weight gain or loss.	0	1	2	3	4	_____
Toileting problems.	0	1	2	3	4	_____
Difficulty concentrating, paying attention.	0	1	2	3	4	_____
Forgetting what is doing or where things were put.	0	1	2	3	4	_____
Impulsivity, hyperactivity.	0	1	2	3	4	_____
Quickly forgetting directions/instructions.	0	1	2	3	4	_____
Cutting classes, refusing to go to school.	0	1	2	3	4	_____
Decline in school performance.	0	1	2	3	4	_____
Inappropriate sexual behavior.	0	1	2	3	4	_____

Other Problems _____

Behavioral Health Information

Please note issues and goals you would like to address and any other current or previous information you feel is important to know in working with you:

Previous Experience with Therapists, Psychiatrists, Hospitalization, Substance Abuse Treatment:
Name _____ Date _____

Physical Medical Information

Primary Care Physician _____ Phone _____

Address _____

List all current Medications

Prescription	DosageTo Treat	Prescribing Physician	Start Date
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Problems and Surgeries

Current	Past
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_____	_____
_____	_____
_____	_____
_____	_____

Allergies _____ None _____

Amount and Frequency of use:

Current

Past

Alcohol_____

Drugs not Prescribed_____

Marijuana_____

Other "Street" Drugs_____

Clinton S. Felker, Ph.D.
Psychologist, License #6127

Confidentiality, Privacy, and Informed Consent

Healthcare providers' obligations and your rights are governed by "HIPAA", the Health Insurance Portability and Accountability Act. This Federal law regulates the use of your information; requires that its privacy is protected; and that you be informed of office policy about your clinical record. This information can be released to others only if you sign an authorization to release confidential records (see exceptions, below). You may restrict information to your insurance company if paying for services out of pocket.

Your signature on this form is your consent for the following uses and releases of information:

1. Case consultation with other healthcare professionals. This may be a "blind" consultation with a therapist with more experience in a problem area to assist treatment plan and strategy. Personal identification will be avoided. Or, a specific consultation/correspondence with another professional involved in your case (Physician, appropriate school personnel, other therapist). Both types of contact are subject to confidentiality regulations, and will be noted in the case records.

1. For business purposes, the billing agency, insurance companies, or collection agency receive only necessary Protected Health Information (PHI) such as name of the policy holder, plan, account number, diagnostic code, fees, and the date and service provided. Confidentiality is maintained by contract agreement with these agencies.

1. Confidentiality in couples or family therapy is not completely clear. Information will only be released with your written permission unless required by law or court order.
2.
Exceptions: Confidential information may be released or required by law without authorization when:
 1. There are indications that a client may hurt themselves or another person, or there are indications that a child or senior citizen has been subjected to abuse.
 1. A minor's parent requests case information unless stipulated by court order that a parent does not have access to medical records.
 1. A court orders release of case information. Note that an attorney's order to release information is protected by client-psychologist privilege unless signed authorization is provided.
 1. Government agencies such as Medicare, Social Security Disability, and Bureau of Workers' Compensation may require case information to assure policy compliance and need for treatment.

1. Complaints or legal action regarding treatment.

In addition to PHI content, your file will include session case notes. These are kept separate and are not to be reviewed or released without specific authorization by you (unless ordered by court). This restriction applies in situations such as file auditing by insurance company, release of medical records requests, etc.

As an extra precaution, most questions involving disclosure of confidential information will be discussed together, and you will have the right to sign authorization or, in some cases, denial to release information. If you have concerns about the privacy of your records or disagree about information being released, you may contact the U.S. Department of Health and Human Services, the governing body for HIPAA.

Addendum: Electronic communication (e-mail or texts) cannot be guaranteed to be entirely secure. As a result, please limit these to requests about appointments. I do not engage social media (Facebook, Twitter) with clients as these are, by nature, not private.

Service and Fee Agreement

Psychological services provided fall into two main categories: psychotherapy for individuals and families; and psychological testing, Billing service codes and related fee schedules are:

90791 Diagnostic Intake/Evaluation:	
90832 Psychotherapy, up to 37 minutes	\$ 75
90834 Psychotherapy, 38 to 52 minutes	\$120
90837 Psychotherapy, 53 minutes and longer	\$170
90847 Family Psychotherapy	\$160
96101 Psychological Testing	\$130

If you are not using insurance, fees can be negotiated according to income. Billing is conducted through BillPro Management Services (440.854.0209). Contracts with insurance typically have a set fee they allow, with higher amounts to be adjusted off of the balance. Plans vary widely in the portion they cover; you are responsible for any applicable annual deductible and co-payments. Additional charges will apply for sessions not covered by your plan, extended phone consultations, and reports to others such as physicians and attorneys Note: You will be charged for services canceled less than 24 hours in advance and for appointments not kept; these fees are not covered by insurance plans and are your responsibility. There may be reasons to cancel without charge such as illness and family emergencies (but not work changes, baby sitter canceled). All charges should be paid at time of service or within 30 days of receiving a billing statement. As allowed by law, overdue accounts without regular payments made may be charged interest (10% APR) or submitted to a collection agency. When needed, payment plans can be arranged, and you will be notified in the monthly statement when an account is overdue.

By signing this form, you agree to pay fees for services provided not covered by your insurance plan.

I have read this agreement and agree to its terms. I am entitled to a copy after signing.

Client or responsible party; parent or guardian for a minor Witness Date