

CHILD AND FAMILY PSYCHIATRIC CENTER
1744 E. McAndrews Rd., Suite B. - Medford, Oregon 97504
Phone (541)776-0821 FAX (541)776-5011

PATIENT REGISTRATON

*Welcome to Child and Family Psychiatric Center.
Please complete all forms and bring them with you to your upcoming appointment.*

PATIENT DEMOGRAPHICS

Child's Name: _____ Today's Date: _____

Gender: M ___ F ___ Age: ___ Date of Birth: _____ Social Security (ID) Number: _____

Custodial Parent's Name: _____

Others living in the home: _____, _____

Mother: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

(Best contact number)

May we leave messages for you on your phone? Yes or No May we email you? Yes or No

Father: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone _____ Email _____

(Best contact number)

May we leave messages for you on phone? Yes or No May we email you? Yes or No

Emergency contact: _____ Phone: _____

Referred by: _____ Phone: _____

Grade in School: _____ School: _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____

Policyholder Name: _____ Date of Birth: _____

Secondary Insurance: _____ Policy #: _____

Policyholder Name: _____ Date of Birth: _____

Assignment and Release:

I, the undersigned, have insurance coverage with _____ and assign to Child and Family Psychiatric Center of Southern Oregon and/or _____, all medical benefits, if any, otherwise, payable to me for services rendered. I agree to be responsible for and to make all payments for services and treatment even after my child reaches the age of majority. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize Child and Family Psychiatric Center of Southern Oregon to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions.

Signature of Patient / Authorized Representative

Relationship to Patient

Print Name

Today's Date

Child and Family Psychiatric Center

Child Initial Background Questionnaire CONFIDENTIAL

Name of Child: _____ DOB: _____ Age: _____

Caregivers: Mother: _____ Age: _____ Employment: _____

Education: HS Diploma College Graduate School Other

Father: _____ Age: _____ Employment: _____

Education: HS Diploma College Graduate School Other

Other caregiver: _____ Age: _____ Employment: _____

Education: HS Diploma College Graduate School Other

Briefly describe the problems that brought you here today. _____

Please check all the symptoms your child is having:

- | | | |
|--|---|--|
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Thoughts of harming others |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Problems with family | <input type="checkbox"/> Feeling fearful |
| <input type="checkbox"/> High Energy | <input type="checkbox"/> Running away | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Talks non-stop | <input type="checkbox"/> Depressed/extreme sadness | <input type="checkbox"/> Problems with sleep |
| <input type="checkbox"/> Problems with peers | <input type="checkbox"/> Feels hopeless | <input type="checkbox"/> Headaches; Stomachaches |
| <input type="checkbox"/> Trouble with organization | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Anger outbursts | <input type="checkbox"/> Isolation/Withdrawal | <input type="checkbox"/> Lots of worries |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Problems eating | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Annoys others | <input type="checkbox"/> Easily tearful | <input type="checkbox"/> Perfectionistic |
| <input type="checkbox"/> Blames others | <input type="checkbox"/> Extreme sadness | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Refuses to comply | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Feelings of guilt |
| <input type="checkbox"/> Aggressive/Violent | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Problems separating from caregiver |
| <input type="checkbox"/> Fire-setting | <input type="checkbox"/> Thoughts of self-harm | <input type="checkbox"/> Problems eliminating bowels/bladder |
| <input type="checkbox"/> Harms animals | <input type="checkbox"/> Has hurt or tried to hurt self | <input type="checkbox"/> Speech and language problems |
| <input type="checkbox"/> Sudden feelings of panic | <input type="checkbox"/> Weight/Appetite changes | |

Has your child been in counseling in the past? Yes No

If yes, with whom _____ Start and End Date: _____

Has your child been prescribed or has she/he taken any medication, including over-the-counters? Yes No

If yes, what? (use additional paper as needed) _____

Reason: _____

Substance Abuse History

Does your child use tobacco? Current Suspected Past No

Does your child use alcohol? Current Suspected Past No

Does your child use caffeine? Current Suspected Past No

Does your child use recreational drugs? Current Suspected Past No

Medical Information

Who is your child's pediatrician? _____

Has your child seen the doctor in the past year? Yes No Reason? _____

How is your child's general health? Very good Good Fair Poor

Has your child had any chronic illnesses? Yes No If yes, what? _____

Does your child have any allergies? Yes No If yes, what? _____

Developmental History

Complications during pregnancy? Yes No If yes, please describe: _____

Duration of pregnancy: Premature Full term Post term

Child's birth weight: _____ pounds _____ ounces

Complications during delivery? Yes No If yes, please describe: _____

Did your child require a stay in the Newborn Intensive Care? Yes No

How long? _____ Reason? _____

Was your child breast-fed? Yes No

As an infant, your child was (please check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Usually easy to feed | <input type="checkbox"/> Usually difficult to feed | <input type="checkbox"/> Usually easy going | <input type="checkbox"/> Happy and content |
| <input type="checkbox"/> Often fussy or irritable | <input type="checkbox"/> Liked to be held and cuddled | <input type="checkbox"/> Was hard to hold | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Good sleeper | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Played peek-a-boo | <input type="checkbox"/> Cried a lot |

Age your child first walked? _____

Age your child spoke first words (other than mamma/dada)? _____ Not talking

Age your child first used two-word sentences? _____ not trained

Age your child toilet trained? _____ bladder not trained _____ bowel not trained

Age of child when primary caregiver returned to work _____ Full time Part time still at home with child

Did mother experience post-partum depression? Yes No If yes, for how long? _____

School History

Please check all of the concerns your child's teacher has reported:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Separation Problems | <input type="checkbox"/> Aggression | <input type="checkbox"/> Opposition | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Poor peer relationships | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Destructive behavior | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Clinginess | <input type="checkbox"/> Excessive crying |
| <input type="checkbox"/> Learning problems | <input type="checkbox"/> Other | | |

Family History

Please check all of the concerns/diagnoses present on the mother's side of the family Unknown

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Drug Addictions/Alcoholism | <input type="checkbox"/> Suicide | <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Trauma | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Autism | <input type="checkbox"/> Other: _____ |

Please check all of the concerns/diagnoses present on the father's side of the family Unknown

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Drug Addictions/Alcoholism | <input type="checkbox"/> Suicide | <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Trauma | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Autism | <input type="checkbox"/> Other: _____ |

Child and Family Psychiatric Center

POLICY ON PATIENT ACCOUNTS

****PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED****

- **Insurance Billing**

As a courtesy to you we will bill your primary insurance, and also your secondary, if the appropriate information is provided to us at the time of service. It is ultimately your responsibility to follow up with them to make sure your account is paid. **We require co-pays at the time of service**, and are able to accept cash, checks, Visa and MasterCard. If we are unable to verify your insurance or you do not present with the correct insurance information you will be responsible for any and all charges incurred. This office does not bill Medicare or the Oregon Health Plan.

_____ (initials)

- **Self-Pay Patients**

Payment is due in full at time of service.

_____ (initials)

- **Payment Arrangements**

If you are unable to pay at the time of the appointment, please contact this office **prior** to appointment to make arrangements.

_____ (initials)

- **Statement Processing Fee**

A monthly statement processing fee of \$2.50 will be accrued for each month a statement must be sent. _____ (initials)

- **Delinquent Accounts**

If you are not able to make payments as agreed and your account becomes delinquent, the account may be turned over to a collection agency. Delinquent accounts are subject to dismissal from our practice.

_____ (initials)

- **Divorce Decrees**

Minor patients only. CFPC is not a party to your divorce decree. The signed party responsible for the account prior to the divorce or separation remains responsible for the account. We will not be involved in mediating financial arrangements between parents/guardians.

_____ (initials)

- **Non-Sufficient Funds**

A \$35 fee will be added to your account for any checks returned due to a non-sufficient fund (NSF). If we receive a NSF we will no longer accept checks for payment – only cash or Visa/MasterCard. You agree to be responsible for NSF charges even if the check is written by another party.

- **Late Cancells and No-Shows**

A minimum fee of \$25.00, up to the full price of the appointment for time reserved, may be charged to your account for missed appointments or appointments canceled less than 24 hours in advance. Excessive no shows or missed appointments are subject to dismissal from our practice.

The above charges will not be submitted to insurance.

_____ (initials)

Patient Signature or Authorized Signature

Relationship to Patient

Printed Name of Patient

Date of Birth

Today's Date

Child and Family Psychiatric Center

ACKNOWLEDGMENT AND CONSENT

I understand that Child and Family Psychiatric Center (referred to below as “CFPC”) will use and disclose **mental health information** about me.

I understand that my **mental health information** may include information both created and received by CFPC, may be in the form of written records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that CFPC may **use and disclose** my mental health information in order to:

- » Make decisions about and plan for my care and treatment;
- » Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- » Determine my eligibility for insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some of all of my health care; and
- » Perform various office, administrative and business functions that support my physicians efforts to provide me with, arrange and be reimbursed for quality health care.

I also understand that I have the right to receive and review a written description of how CFPC will handle mental health information about me. This written descriptions is known as a **Notice of Privacy Practices** and describes the uses and disclosures of mental health information made and the information practices followed by the employees, staff and other office personnel of CFPC, and my rights regarding my mental health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of CFPC's Notice of Privacy Practices in effect will be posted in waiting / reception areas.

I understand that I have the right to ask that some or all of my mental health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that CFPC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____
(Patient Signature)

Date: _____

Patient Name: _____

Date of Birth: _____

By: _____
(Patient Representative)

Date: _____

Child and Family Psychiatric Center

OFFICE POLICY

OUR MISSION

“Bringing together expert clinicians from every mental health discipline and providing excellent, integrated treatment to the children, teens and working age adults in our region. We always strive to deliver up-to-date, comprehensive care to heal and empower all those we serve.”

Office Hours

Child and Family Psychiatric Center office hours are Monday through Friday from 9:00 am to 5:00 pm. Each individual practitioner's hours may vary. Some early morning and later evening appointments are available.

All appointments are booked through our receptionist in person or by calling our office at (541)776-0821. You will always be seen as promptly as possible. To insure that you are here on the proper day and time, please check in with our receptionist upon your arrival. If you find you must cancel your appointment, we require that you inform us at least 24 hours before the scheduled appointment time.

After Hours

Child and Family Psychiatric Center is not a crisis center, if you are experiencing a life threatening emergency dial 911 or go to the Rogue Regional Medical Center Emergency Room. We do have an after hours phone service that can be reached by dialing our main number at (541)776-0821 and pressing 0 when prompted, an operator will locate your doctor or therapist.

Prescription Refills

Please call your pharmacy at least 2 working days in advance when a prescription requires refilling. This will allow sufficient time for the pharmacy to contact the doctor for his/her authorization to refill your prescription. If your prescription requires it be on paper then please allow us 1-2 business days to complete this for you by calling our office at (541)776-0821. Prescriptions and refills are issued during office hours only. Our physicians do not routinely write prescriptions or issue refill requests during the evenings or weekends because your medical records are not available.

Referrals

We are proud to offer a multidisciplinary team to handle your mental health care needs. Interoffice referrals are available for medication management and counseling. Ask your provider or our office staff for information on other services provided at our office.

Contact Us

Our office is located at 1744 E. McAndrews Rd., Suite B Medford, Oregon 97504.
Office phone number (541)776-0821. Office FAX number (541)776-5011. E-mail address staff@childfpc.com.
Website: www.childandfamilypsychiatriccenter.com

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