Palo Alto Medical Foundation

A Sutter Health Affiliate

Treatment Policies and Financial Agreement
Department of Psychiatry and Behavioral Health

The agreement stated below is to inform our patients about the policies of the Department of Psychiatry and Behavioral Health. If you have any questions not covered by this statement, please feel free to ask for clarification.

CONFIDENTIALITY AND RELEASE OF INFORMATION

- All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Palo Alto Medical Foundation (PAMF) without your written permission, except for disclosures as required by law. The law does require a therapist to report to the authorities when there is reasonable suspicion of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken.
- To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, PAMF may disclose portions of the patient's medical record and account file to any person or corporation that may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. Specific permission will be necessary prior to release of this information for patients being treated in an alcohol or drug program or having certain other diagnoses and treatment.

FINANCIAL AGREEMENT

- It is a patient's responsibility to know his/her insurance coverage for mental health, as your mental health benefits and general medical coverage may be provided by two separate plans. Consult the insurance benefits booklet for your type of coverage, especially health maintenance organization (HMO) patients. Many plans have limited or no contractual coverage with PAMF. Therefore, you will be billed and held responsible for all non-covered services.
- HMO patients assigned to other Primary Medical Groups (PMG) outside the Palo Alto Medical Foundation (PAMF) will be billed for all laboratory work and ancillary services performed at the Palo Alto Medical Foundation. These will be the patient's responsibility to pay unless prior authorization is obtained from the patient's PMG that states that the PMG will be responsible to pay for ancillary services. For HMO coverage where a prior authorization has not been obtained, patients should have their laboratory work performed at their PMG and have the laboratory results transferred to our clinicians.
- You will be billed for telephone calls, written reports or other services that specifically require a clinician's time.
- Co-payments are to be paid at the time of visit or within 30 days of receiving your statement.
- Patients in poor credit standing with PAMF will make their co-payments or payment in full at the time of their visit. Please make your checks payable to the Palo Alto Medical Foundation (PAMF).
- Fee-for-service Medicare patients who fail to appear or cancel an appointment within 24 hours of an appointment will be charged the full fee for that appointment. Charges for cancelled appointments that are not paid may be assigned to a collection agency. We charge at a minimum $195 to $333 for initial appointments and we charge $146 to $169 for regular routine consultations.
- You have 30 days after receiving your statement to dispute a billing error. If an account is referred to collections, the patient or patient's guarantor shall be responsible for the attorney's fees and collection expenses.

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Patient name: ______________________

Date: ______________________

Department of Psychiatry and Behavioral Health

Child Symptom Checklist

Please circle the appropriate degree of any symptoms you have experienced in the last month.

1=Never 2=Rarely 3=Occasionally 4=Frequently 5=Usually

Symptom					
Has trouble sleeping	1	2	3	4	5
Has poor appetite	1	2	3	4	5
Seems sad or unhappy	1	2	3	4	5
Talks about feeling stupid or worthless	1	2	3	4	5
Loss of interest in having fun	1	2	3	4	5
Seems irritable	1	2	3	4	5
Moody	1	2	3	4	5
Plays alone	1	2	3	4	5
Cries easily	1	2	3	4	5
Seems tired	1	2	3	4	5
Wishes he/she were dead	1	2	3	4	5
Self injurious behavior	1	2	3	4	5
Suicidal thoughts/gestures	1	2	3	4	5
Complains of physical problems, i.e headaches, stomach aches, etc	1	2	3	4	5
Worries	1	2	3	4	5
Lacks confidence in his/her abilities	1	2	3	4	5
Needs lots of reassurance	1	2	3	4	5
Needs to be perfect	1	2	3	4	5
Seems fearful and anxious	1	2	3	4	5
Seems shy or timid	1	2	3	4	5
Easily embarrassed	1	2	3	4	5
Sensitive to criticism	1	2	3	4	5
Bites fingernails	1	2	3	4	5
Always on the go	1	2	3	4	5
Makes careless mistakes	1	2	3	4	5
Can't sit still, fidgets, squirms in seat	1	2	3	4	5
Doesn't seem to listen	1	2	3	4	5
Often fails to finish things	1	2	3	4	5
Has poor concentration/attention with school work	1	2	3	4	5
Often fidgets with hands or feet or squirms in seat	1	2	3	4	5
Easily distracted, forgetful	1	2	3	4	5
Has hard time playing quietly	1	2	3	4	5
Talks excessively	1	2	3	4	5
Often interrupts or "butts in" to others' games	1	2	3	4	5
Seems disorganized, loses things often	1	2	3	4	5
Takes risks without considering the danger	1	2	3	4	5
Blurts out answers to questions before they have been completed	1	2	3	4	5
Difficulty with delays in speech/language or motor/physical coordination	1	2	3	4	5
Difficulty with learning to write, math spelling, reading	1	2	3	4	5
Refuses to follow rules or do chores	1	2	3	4	5
Loses temper	1	2	3	4	5
Argues with parents or teachers	1	2	3	4	5
Blames others for his/her mistakes	1	2	3	4	5
Swears	1	2	3	4	5
Deliberately does things to annoy other people	1	2	3	4	5
Is angry, resentful, carries grudges	1	2	3	4	5
Touchy, easily annoyed by others	1	2	3	4	5
Steals	1	2	3	4	5
Runs away overnight	1	2	3	4	5
Lies	1	2	3	4	5
Cuts school	1	2	3	4	5
Is cruel to animals	1	2	3	4	5
Destroys property	1	2	3	4	5
Gets into fights	1	2	3	4	5
Has been cruel to other people	1	2	3	4	5
Doesn't seem sorry for hurting others	1	2	3	4	5
Sets fires	1	2	3	4	5
Has broken into a house or car	1	2	3	4	5
	1	2	3	4	5
Difficulty in controlling anger	1	2	3	4	5
Homicidal thoughts	1	2	3	4	5
Tics or motor twitching	1	2	3	4	5
Phobias/specific fears	1	2	3	4	5
Fear of separation from parent	1	2	3	4	5
Fear of social situations	1	2	3	4	5
Repetitive/bothersome thoughts	1	2	3	4	5
Repetitive behaviors/compulsions	1	2	3	4	5
Excessive worry	1	2	3	4	5
Overeating/binging	1	2	3	4	5
Eating too little/anorexia	1	2	3	4	5
Purging food by vomiting or laxative use	1	2	3	4	5
Grades suddenly lower than previously	1	2	3	4	5
Alcohol/substance use/abuse/dependency	1	2	3	4	5
Dramatic mood swings	1	2	3	4	5
Sexually acting out	1	2	3	4	5
Lacks eye contact	1	2	3	4	5
Prefers to play alone, ignores others	1	2	3	4	5
Has lost abilities that he/she once had	1	2	3	4	5
Repetitive gestures/movements when stressed	1	2	3	4	5
Seeing things not really there/hears voices	1	2	3	4	5
Other unusual perceptions/beliefs	1	2	3	4	5

GENERAL MEDICAL CONSENT

The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to medical services, X-ray and laboratory examinations rendered to the patient by or under the general or special instructions of the physicians(s) or other licensed health care professional(s) practicing within the Palo Alto Medical Foundation.

CANCELLED APPOINTMENTS

- A patient who fails to appear at or cancels within 24 business hours of an appointment will be charged for that appointment. The fee will be based on the provision of your insurance contract. Patients who are self-pay may be charged the full fee. Charges for cancelled appointments that are not paid may be assigned to a collection agency.

Repeated "no-shows" may jeopardize your ability to receive treatment.

EMERGENCY SERVICES

- The on-call services are for emergencies only. Please call:

  Palo Alto: (650) 853-2904 or (650) 321-4121
  Fremont Center: (510) 490-1222
  Redwood Shores Center: (650) 598-3160

- After hours, on-call emergency services will be charged at a higher fee.

- Due to our providing emergency services to others, your appointment may need to be rescheduled on short notice.

The undersigned certifies that he or she has read, understands, and accepts the terms and conditions of this form. The undersigned is either the patient or is duly authorized to sign this form and receive a copy.

____

Signature of Patient/Parent/Conservator/Guardian/Legal Representative Date

____

Witness's Signature Date

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Child/Adolescent Intake Form

Child's Name ________________________ SEX: ❒ M ❒ F Age:______ Date of Birth: ________________

Ethnicity: ______________ Adopted/Custody: ❒ Yes ❒ No Explain: ___________ Place of Birth: ______________

Parent's or Guardian's Name ____

Address:____

Home phone: ______________ Work phone: ______________ Cellular phone: ________________________

Parent's are: ❒ single ❒ married ❒ separated ❒ divorced ❒ remarried ❒ widowed ❒ cohabitating

If divorced, what are the custody arrangements? ____________ (Please bring copy of custody agreement for the chart)

Please give other parent's address and phone number.

Name ____

Address: ____

Home phone number: ______________________ Work phone number: ________________________

Name of Physician(s): ________________________________ Phone number: ________________________

Psychiatrist/other professional: ___________________________ Phone number: ________________________

Household Members

Name	Age	Relationship	Occupation/Grade

Family Members Not Living in Household (e.g., stepchildren, adult children, etc.)

Name	Age	Relationship	Occupation/Grade

AREAS OF CONCERN (check all that apply):

Personal/Social Adjustment:

( ) Unduly sad
( ) Overly anxious
( ) Overly aggressive
( ) Temper tantrums
( ) Withdrawn or shy
( ) Disturbing habits or mannerisms
( ) Strange or bizarre behavior
( ) Problems in peer relationships
( ) Drug or alcohol problems
( ) Problems with the law
( ) Harms self or others (suicidal or homicidal)
( ) Other (please specify):

____
____
____

Family Adjustment

( ) Parent-child problem
( ) Marital conflict or coparenting problems
( ) Sibling conflict
( ) Recent family changes
( ) Neighborhood difficulties
( ) Mother experiencing difficulties
( ) Father experiencing difficulties
( ) Sibling experiencing difficulties
( ) Drug or alcohol problems in family
( ) History of trauma or loss
( ) Domestic violence
( ) Abuse
( ) Other (please specify):

____
____
____

School Adjustment

( ) Academic problems
( ) Difficulty with peers
( ) Difficulty with authority
( ) Attendance problems or reluctance to go to school
( ) Behavior problems
( ) Learning disabilities
( ) Attentional problems
( ) Aches and pains related to school
( ) Other (please specify):

____
____
____

Physical/Developmental Factors

( ) Eating
( ) Sleeping
( ) Toileting
( ) Grooming
( ) Language or speech
( ) Perceptual/visual functions
( ) Motor coordination problems
( ) Other, (please specify):

____
____
____

HISTORY OF CURRENT PROBLEM

Duration and primary concern (include changes in mood, behavior, sleep, eating, free-time activities, school concerns). Please use backside of page for important history.

What have you already done to address this concern and how effective were these efforts?

Was there an event that caused you to seek treatment now? _______ If yes, please describe.

SCHOOL HISTORY

Current grade level: ____ Current school:________________________ Teacher's name: __________________________________

School address: ___________________________________ Phone:_________________ Fax: ______________________________

Please summarize child's progress (e.g., academic, social), within each of these grade levels:

Preschool

Kindergarten

Grades 1-3

Grades 4-5

Grades 6-8

Grades 9-12

Has child ever been evaluated? _____ School Study Team (SST) _____ Individualized Educational Program (IEP) _____
What was the outcome of the evaluation? Accommodations?

Date

Learning disabilities class _______ _____________________________

Behavioral/emotional disorders class _______ _____________________________

Resource room _______ _____________________________

Speech and language therapy _______ _____________________________

Suspended, expelled, retained _______ _____________________________

Other (please specify): _______ _____________________________

Other evaluations: Psychological, Educational, Speech, Occupational Therapy
(please bring copies to the intake evaluation).

Type of evaluation	Name and phone number of evaluator	Date of exam	Outcome

PAST PSYCHIATRIC HISTORY: Check those that apply.

Outpatient psychotherapy: ❒ Yes ❒ No

❒ Family therapy- How long? _______ ❒ Individual therapy- How long? _______ ❒ Group therapy- How long? _______

Inpatient (Hospital or Residential): ❒ Yes ❒ No If yes, where and when? ________________________________

Past suicidal ideation? ❒ Yes ❒ No Plan? ❒ Yes ❒ No Number of attempts and dates: ____________________

Current suicidal ideation? ❒ Yes ❒ No Plan? ❒ Yes ❒ No Most recent attempt date:_______ Method:_______________

Previous diagnosis: ____

Name of treating psychotherapist or psychiatrist: ____________________________________

Address: ________________________________ Phone number: ____________________ Fax:__________________

MEDICAL HISTORY:

Any significant or relevant medical problem (e.g. allergies, asthma, accidents and dates, surgery and dates, abuse and dates):

Chronic condition or disability: ____

Medication of any kind child is currently taking:

Medication	Dosage	Frequency	Purpose

Has child had an allergic reaction or other problems with medications? Yes_____ No_____

If yes, which drugs, and briefly explain: ____

____

HABITS (list amounts and frequency):

Alcohol or Drugs: ______________________________ Caffeine: ______________________________

Vitamins: ______________________ Herbal Supplements: ______________________________

Exercise (amount/type/frequency): ____

Sleep: __________________________ Eating: ______________________________

Other: ____

FAMILY OF ORGIN HISTORY

Please list below family member(s) who have (or had) emotional problems, depression, anxiety, psychiatric illness, drug or alcohol abuse, attentional difficulties, learning disabilities, autism, developmental delays or retardation, abuse, neglect, suicide attempts, etc.

Family Member (relationship to child)	Problem	On-going	Resolved

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Developmental Factors

A. Prenatal History

1. Mothers health during pregnancy was: ❒ Good ❒ Fair ❒ Poor

2. Age of mother at child's birth?
   ❒ Under 20 ❒ 20-24 ❒ 25-29 ❒ 30-34 ❒ 35-39 ❒ 40-44 ❒ Over 44 ❒ Unknown

3. Did mother use any of these substances or medications during pregnancy?

Beer/wine:	Never, once or twice,	3 – 9 times,	10 – 19 times,	20 – 39 times,	40+ times
Coffee/caffeine:	Never, once or twice,	3 – 9 times,	10 – 19 times,	20 – 39 times,	40+ times
Hard liquor:	Never, once or twice,	3 – 9 times,	10 – 19 times,	20 – 39 times,	40+ times
Cigarettes:	Never, once or twice,	3 – 9 times,	10 – 19 times,	20 – 39 times,	40+ times
Tranquilizers/: (Sleeping pills)	Never, once or twice,	3 – 9 times,	10 – 19 times,	20 – 39 times,	40+ times
Other:__________	Never, once or twice,	3 – 9 times,	10 – 19 times,	20 – 39 times,	40+ times

4. Did you have toxemia or eclampsia? ❒ No ❒ Yes

5. Was there Rh factor incompatibility? ❒ No ❒ Yes

6. Child born on schedule? __________, If early, how premature____________________

7. Duration of labor? ___________

8. Fetal distress during labor? ❒ No ❒ Yes

9. Was delivery: ❒ Normal ❒ Breech ❒ Caesarian ❒ Forceps ❒ Suction ❒ Induced

10. Child's birth weight? ____________ APGAR Score ____________

11. Were there complications following birth? ❒ No ❒ Yes
    If yes, what were they? ____

____

____

____

____

____

B. Postnatal Period / Infancy / Toddler

1. Feeding problems ❐ No ❐ Yes

2. Colic? ❐ No ❐ Yes

3. Sleep pattern difficulties? ❐ No ❐ Yes

4. Problems with responsiveness (alertness)? ❐ No ❐ Yes

5. Were there health or congenital problems during infancy? ❐ No ❐ Yes

6. How was it to care for this child?
   ❐ Very easy ❐ easy ❐ average ❐ difficult ❐ very difficult

7. How did the child behave with other people?
   ❐ More sociable that average ❐ average sociability ❐ more unsociable than average

8. When the child wanted something, how insistent was (s)he?
   ❐ Very insistent ❐ pretty insistent ❐ average ❐ not very insistent ❐ not at all insistent

9. Rate the activity level of the child:
   ❐ Very active ❐ active ❐ average ❐ less active ❐ not active

C. Developmental Milestones

1. Age child sat up: ❐ 3-6 months ❐ 7-12 months ❐ Over 12 months

2. Age child crawled: ❐ 6-12 months ❐ 13-18 months ❐ Over 18 months

3. Age child walked alone: ❐ Under 1 year ❐ 1-2 years ❐ 2-3 years

4. Age child spoke single words other that 'mama' or 'dada'?
   ❐ 9-13 months ❐ 14-18 months ❐ 19-24 months ❐ 25-36 months ❐ 37-48 months

5. Age child strung two or words together:
   ❐ 9-13 months ❐ 14-18 months ❐ 19-24 months ❐ 25-36 months ❐ 37-48 months

6. Age toilet trained?
   Bladder controlled: ❐ Under 1 year ❐ 1-2 years ❐ 2-3 years ❐ 3-4 years
   Bowel controlled: ❐ Under 1 year ❐ 1-2 years ❐ 2-3 years ❐ 3-4 years

7. How long did toilet training take from onset to completion?
   ❐ Less than 1 month ❐ 1-2 month ❐ 2-3 months ❐ More than 3 months

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Contact Phone Numbers

I wish to be contacted in the following manner: (check all that apply)

_____ **Home Telephone Number:** _________________

_____ Ok to leave message with detailed information with spouse, family member, domestic partner, caregiver or answering machine.

_____ Leave message with callback number only

_____ **Work Telephone Number:** _________________

_____ Ok to leave detailed message.

_____ Leave message with call back number only.

_____ **Mobile Telephone Number:** ____________________

_____ Ok to leave detailed message.

_____ Leave message with callback number only.

Please note: It is the patient's responsibility to inform us of any changes.

________________________ Signature of Patient

______________ Date