LoCiceroHealth

Child & Adolescent Psychiatry
New Patient Forms

Please do not mail or fax this form.
Bring it with you to your appointment.

.

Patient Name: _____

Address: _____
Street **City** **State** **ZIP Code**

Email address: _____

Home phone: (_____) _____ **Cell phone**: (_____) _____

Date of Birth: _____ **Sex**: M / F **Marital status:** _____

Social Security #: _____ **Driver License #:**_____

Student: Y / N **If yes:** Full- or Part-time **Are you Hispanic or Latino:** Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street **City** **State** **ZIP Code**

Phone: (_____) _____ **Extension:** _____

Emergency Contact: _____

Relationship to patient:_____

Primary phone: (_____) _____ **Alternate phone**: (_____) _____

Address: _____
Street **City** **State** **ZIP Code**

Primary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured:** _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured:** _____

Secondary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature:** _____

I hereby authorize LoCicero Health to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to LoCicero Medical Group or to the party who accepts assignment.

I certify the information I have provided with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

Date: _____ **Signature:** _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Date: _____ **Signature:** _____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

( ) I HAVE MADE SUCH A DECLARATION.

( ) I HAVE **NOT** MADE SUCH A DECLARATION.

Health Care Surrogate

( ) I HAVE DESIGNATED A HEALTH CARE SURROGATE.

( ) I HAVE **NOT** DESIGNATED A HEALTH CARE SURROGATE.

Durable Power of Attorney

( ) I HAVE APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

( ) I HAVE **NOT** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

Signature of Patient or Representative Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Representative Date

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date

LoCicero Health

110 South MacDill Ave
Suite 300
Tampa, FL 33609 Phone
904-383-1038 Fax 904-383-1660

Date of Appointment: _____
Chronologic Age: _____

Today's Date: _____

Child & Adolescent Patient History Questionnaire

Child's Name:
Nickname?
Date of Birth:

Mother's Name:
Relationship: (step, adoptive, foster, etc)
Address:
Home and/or Cell Phone:

Father's Name:
Relationship: (step, adoptive, foster, etc)
Address:
Home and/or Cell Phone:

Referred By:

What Are Your Concerns About Your Child?
When Did You Begin To Notice These Concerns?
Additional Concerns:

Past Psychiatric History
Has your child ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

_____
_____
_____
Has your child ever seen a psychologist?_____
_____
_____
_____
Has your child ever seen a therapist?_____
_____
_____
_____
Has your child ever been hospitalized for psychiatric reasons? If so, where and when?
_____
_____
_____
_____

Please circle the behaviors below that pertain to your child.

Nervous	Hyperactive	Temper tantrums	Poor sleep
Short attention span	Cries easily	Behavior problems	Destroys property
Easily frustrated	Excessive fears	Motor tics	Bite nails
Pulls hair	Frequent headaches	Frequent stomachaches	Fatigue/easily tired
Harms self (ie. cutting)	Hurts others (hits, bites, kicks)	Overweight	Perfectionist
Shy	Does not follow rules	Worries a lot	Overly talkative
Low self esteem	Likes self	Withdrawn/sullen	Slow learner
Demands attention	Plays well with peers	Irritable	Trouble making friends
Prefers to play alone	Depressed/sad	Legal problems	Weird ideas/bizarre thoughts
Running away from home	Vision problems	Hearing problems	Speech problems
Sexually active	Alcohol use	Drug use	Tobacco use
Legal Problems	Head Injury		

Medications: Please list all medications or supplements taken by your child.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*
1.		
2.		
3.		
4.		

5.		
6.		
7.		
8.		
9.		
10.		

Past Medical History:

Primary Care Physician:
Clinic Name, Address, and Phone #:

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Previous Surgeries	Approximate Date	Location/Hospital
1.		
2.		
3.		

Previous Hospitalizations	Approximate Date	Location/Hospital
1.		
2.		
3.		

Medication Allergies:
Food Allergies:
Are Immunizations Up-to-Date?

Developmental History:
Pregnancy:

Mother's Age During Pregnancy:	Prenatal Care Began in Which Trimester? 1st 2nd 3rd
How many total pregnancies for mother?	Which pregnancy was this one?
Any complications during the pregnancy? *ie. pre-term labor, high blood pressure, gestational diabetes*	Maternal drug, alcohol, or tobacco use during pregnancy?

Labor and Delivery:

Due Date:	Birth Date:
Hospital:	City, State:
Vaginal or C-Section?	Forceps or Vacuum Assisted?
Anesthesia? Epidural, Spinal, General, IV, None	Length of Labor?
APGAR Scores?	Birth Weight?
Complications During Delivery?	

Neonatal History:

Was your baby in the NICU?	How long did your baby stay in the hospital?
Did your baby have any nursery complications? Jaundice? Feeding problems? Infections?	Did your baby require resuscitation or oxygen?

Milestones: Please provide the age (in months) when your child attained the following milestone.

Sit unassisted	Hand-knee crawl
Walk independently	Pedal a trike
Finger feed	Toilet trained
Use "mama/dada" only for parent	First word
Point to indicate needs/wants	Used 10-15 words
Used 50 words	Put two words together

Family/Social History:

Who lives in the child's home?_____

Does the child have a second home where they spend part of the week?_____

Are parents married/partnered/separated/divorced?_____

How long have parents been married (*if applicable*)?_____

Mother	**Father**
Name:	Name:
DOB:	DOB:
Education Level:	Education Level:
Occupation/Employment:	Occupation/Employment:
Medical History:	Medical History:
Psychiatric History:	Psychiatric History:

Step-Mother *(if applicable)*	**Step-Father** *(if applicable)*

Name:	Name:
DOB:	DOB:
Education Level:	Education Level:
Occupation/Employment:	Occupation/Employment:
Medical History:	Medical History:
Psychiatric History:	Psychiatric History:

Siblings					
Name	DOB & Age	Relationship *(full,1/2,step,etc)*	Grade	Medical Problems?	Psychiatric Problems?

Family History: Please indicate if there is a family history of the following conditions and who is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Educational History:

Current School:	County/School District:
Address:	Phone Number:
Grade:	Type of Class: *Regular, Inclusion, Self-Contained, etc?*
Does your child have an IEP or 504 Plan?	Is your child in Exceptional Student Education (ESE)?
Does your child receive Speech Therapy at school?	Exceptionalities: *SLD, Autism, OHI, etc?*
Does your child receive Occupational Therapy at school?	Does your child receive Physical Therapy at school?
Has your child ever been suspended from school?	Has your child ever been expelled from school?

Please list the previous schools that your child has attended:

Years	Grades	School Name	Type of Class	Any problems? *Suspensions, Expulsions, etc*

Legal History:

Arrest(s):	Date(s):

Substance Abuse History *please include age of first use and frequency if known***:**

Alcohol First Used: Frequency:	**Marijuana (weed)** First Used: Frequency:
Cocaine (crack, coke) First Used: Frequency:	**Tobacco** First Used: Frequency:
Opiates (heroin, pain killers, methadone) First Used: Frequency:	**Benzodiazepines (Xanax, Klonopin, Ativan, Valium)** First Used: Frequency:
MDMA (ecstasy) First Used: Frequency:	**LSD (acid, hallucinogens**) First Used: Frequency:
Over the Counter (cough syrup, triple C's, laxatives) First Used: Frequency:	**Bath Salts, Spice, K2** First Used: Frequency:
Amphetamines (speed, Adderall, Ritalin) First Used: Frequency:	**Inhalants (dusters, whip its**) First Used: Frequency:
Other: First Used: Frequency:	**Other:** First Used: Frequency:

Any other issues not yet addressed?

Past Psychiatric Medication

Anti Depressants	**Response (Good, Fair, Poor)**	**Antipsychotic**	**Response (Good, Fair, Poor)**
Amitriptyline (Elavil)		Olanzapine (Zyprexa)	
Bupropion (Wellbutrin)		Perphenazine (Trilafon)	
Citalopram (Celexa)		Pimozide (Orap)	
Clomipramine (Anafranil)		Quetiapine (Seroquel)	
Desipramine (Norpramin)		Risperidone (Risperdal)	
Doxepin (Sinequan)		Asenapine (Saphris)	
Escitalopram (Lexapro)		Thioridazine (Mellaril)	
Fluoxetine (Prozac)		Thiothixene (Navane)	
Fluvoxamine (Luvox)		Trifluperazine (Stelazine)	
Imipramine (Tofranil)			
Mitrazapine (Remeron)		**Mood Stabilizers**	
Nefazodone (Serzone)		Carbamazepine (Tegretol)	
Nortriptyline (Pamelor)		Gabapentin (Neurontin)	
Paroxetine (Paxil)		Lamotrigine (Lamictal)	
Phenelzine (Nardil)		Lithium (Lithobid, etc)	
Dexvenlafaxine (Pristiq)		Topiramate (Topamax)	
Sertraline (Zoloft)		Valproic Acid (Depakote, etc)	
Tranylcypromine (Parnate)			
Trazodone (Desyrel)		**ADHD Medications**	
Venlafaxine (Effexor)		Amphetemine salts (Adderall, etc)	
		Clonidine (Kapvay, Catapres)	
AntiAnxiety		Dexmethylphenidate (Focalin)	
Alprazolam (Xanax)		Guanfacine (Intuniv, Tenex)	
Buspirone (Buspar)		Methylphenidate (Ritalin, Concerta, Daytrana, etc)	
Chlordiazepoxide (Librium)		Strattera (Atomoxetine)	
Clonazepam (Klonopin)		Vyvanse (Lisdexamfetamine)	
Clorazepate (Tranxene)			
Diazepam (Valium)		**Miscellaneous**	
Flurazepam (Dalmane)		Thyroid (Synthroid, Cytomel)	
Hydroxyzine (Vistaril)		Dilantin (Phenytoin)	
Lorazepam (Ativan)		Propranolol (Inderal)	
Oxazepam (Serax)		Naltrexone (Revia)	
Temazepam (Restoril)		Benztropine (Cogentin)	
Triazolam (Halcion)		Trihexyphenidyl (Artane)	
Zolpidem (Ambien)		L-Dopa	
Antipsychotic			
Aripiprazade (Abilify)		**Other Medications**	
Fluphenazine (Prolixin)			
Haloperidol (Haldol)			
Lurasidone (Latuda)			

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Addressed or Fax No.	Description of Disclosure	By Whom Disclosed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LoCicero Health
2605 W. Swann Ave., Suite 600
Tampa, FL 33609
Tele: (813) 876-7073
Fax: (813) 877-1277

PRIVATE PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PATIENT OF RECORD DISCLOSURES

In general, the HIPAA privacy rules give the individual the right to request a restriction on uses and disclosures of private information (PHI). The individual is also provided the right to request confidential communication of PHI, be made by alternative means, such as sending correspondence to the individual's office instead of home.

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

[ ] Home Telephone: _____
- [ ] O.K. to leave message with detailed information
- [ ] Leave message with call back number only

[ ] Work Telephone: _____
- [ ] O.K to leave message with detailed information

[ ] Written Communication
- [ ] O.K. to mail to my home address.
- [ ] O.K. to mail to my work/office address
- [ ] O.K. to fax to: _____

[ ] Other: _____

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use of disclosure of PHI, and for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will provide adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in emergency.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

Name: _____ **Date**: _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When I feel frightened, it is hard for me to breathe	o	o	o
2.	I get headaches when I am at school	o	o	o
3.	I don't like to be with people I don't know well	o	o	o
4.	I get scared if I sleep away from home	o	o	o
5.	I worry about other people liking me	o	o	o
6.	When I get frightened, I feel like passing out	o	o	o
7.	I am nervous	o	o	o
8.	I follow my mother or father wherever they go	o	o	o
9.	People tell me that I look nervous	o	o	o
10.	I feel nervous with people I don't know well	o	o	o
11.	My I get stomachaches at school	o	o	o
12.	When I get frightened, I feel like I am going crazy	o	o	o
13.	I worry about sleeping alone	o	o	o
14.	I worry about being as good as other kids	o	o	o
15.	When I get frightened, I feel like things are not real	o	o	o
16.	I have nightmares about something bad happening to my parents	o	o	o
17.	I worry about going to school	o	o	o
18.	When I get frightened, my heart beats fast	o	o	o
19.	I get shaky	o	o	o
20.	I have nightmares about something bad happening to me	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 2 of 2 (To be filled out by the CHILD)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	I worry about things working out for me	o	o	o
22.	When I get frightened, I sweat a lot	o	o	o
23.	I am a worrier	o	o	o
24.	I get really frightened for no reason at all	o	o	o
25.	I am afraid to be alone in the house	o	o	o
26.	It is hard for me to talk with people I don't know well	o	o	o
27.	When I get frightened, I feel like I am choking	o	o	o
28.	People tell me that I worry too much	o	o	o
29.	I don't like to be away from my family	o	o	o
30.	I am afraid of having anxiety (or panic) attacks	o	o	o
31.	I worry that something bad might happen to my parents	o	o	o
32.	I feel shy with people I don't know well	o	o	o
33.	I worry about what is going to happen in the future	o	o	o
34.	When I get frightened, I feel like throwing up	o	o	o
35.	I worry about how well I do things	o	o	o
36.	I am scared to go to school	o	o	o
37.	I worry about things that have already happened	o	o	o
38.	When I get frightened, I feel dizzy	o	o	o
39.	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	o	o	o
41.	I am shy	o	o	o

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date**: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When my child feels frightened, it is hard for him/her to breathe	o	o	o
2.	My child gets headaches when he/she is at school	o	o	o
3.	My child doesn't like to be with people he/she doesn't know well	o	o	o
4.	My child gets scared if he/she sleeps away from home	o	o	o
5.	My child worries about other people liking him/her	o	o	o
6.	When my child gets frightened, he/she feels like passing out	o	o	o
7.	My child is nervous	o	o	o
8.	My child follows me wherever I go	o	o	o
9.	People tell me that my child looks nervous	o	o	o
10.	My child feels nervous with people he/she doesn't know well	o	o	o
11.	My child gets stomachaches at school	o	o	o
12.	When my child gets frightened, he/she feels like he/she is going crazy	o	o	o
13.	My child worries about sleeping alone	o	o	o
14.	My child worries about being as good as other kids	o	o	o
15.	When he/she gets frightened, he/she feels like things are not real	o	o	o
16.	My child has nightmares about something bad happening to his/her parents	o	o	o
17.	My child worries about going to school	o	o	o
18.	When my child gets frightened, his/her heart beats fast	o	o	o
19.	He/she gets shaky	o	o	o
20.	My child has nightmares about something bad happening to him/her	o	o	o

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

		0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21.	My child worries about things working out for him/her	o	o	o
22.	When my child gets frightened, he/she sweats a lot	o	o	o
23.	My child is a worrier	o	o	o
24.	My child gets really frightened for no reason at all	o	o	o
25.	My child is afraid to be alone in the house	o	o	o
26.	It is hard for my child to talk with people he/she doesn't know well	o	o	o
27.	When my child gets frightened, he/she feels like he/she is choking	o	o	o
28.	People tell me that my child worries too much	o	o	o
29.	My child doesn't like to be away from his/her family	o	o	o
30.	My child is afraid of having anxiety (or panic) attacks	o	o	o
31.	My child worries that something bad might happen to his/her parents	o	o	o
32.	My child feels shy with people he/she doesn't know well	o	o	o
33.	My child worries about what is going to happen in the future	o	o	o
34.	When my child gets frightened, he/she feels like throwing up	o	o	o
35.	My child worries about how well he/she does things	o	o	o
36.	My child is scared to go to school	o	o	o
37.	My child worries about things that have already happened	o	o	o
38.	When my child gets frightened, he/she feels dizzy	o	o	o
39.	My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	o	o	o
40.	My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	o	o	o
41.	My child is shy	o	o	o

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a physician. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this agreement provides consent for those activities as follows:

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the physician-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. Generally, it is not in your best interest to break your confidentiality
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or a lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to suspect child abuse or neglect, the law requires that I file a report with the Family Independence Agency. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to suspect the "criminal abuse" of an adult patient, I must report it to the police. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates a threat of physical violence against a reasonably identifiable third person and the patient has the apparent intent and ability to carry out that threat in the foreseeable future, I may have to disclose information in order to take protective action. These actions may include notifying the potential victim (or, if the victim is a minor, his/her parents and the County Department of Social Services) and contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

While these written exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have

now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulties of legal involvement, I charge $1,000.00 per hour for preparation and attendance at any legal proceeding.

FORMS POLICY

We do not complete leave forms (from work or for disability) of any kind on patients who have not been established with the psychiatric practice for less than 6 months.

EMOTIONAL SUPPORT ANIMALS

We do not provide letters for emotional support animals.

MEDICATION MANAGEMENT

By working together, it is agreed upon that there will only be one clinician providing psychotropic medications. If psychotropic medications are prescribed by an outside provider that is not discussed with me, you will be discharged from my practice. If you begin taking controlled medications of any kind, it is your responsibility to notify me. If you are on a controlled medication, in-person office visits are required once yearly.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that patients over 14 years old can consent to and control access to information about their own treatment. While privacy in psychiatry is crucially important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to request an agreement from any patient between 14 and 18 and his/her parents allowing me to share general information with parents about the progress of treatment and the child's attendance at scheduled visits. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

SIGNATURE

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Name (print) _____

Signature _____

Date of birth _____