



Responsive Centers for Psychology and Learning

7501 College Boulevard, Suite 250 ♦ Overland Park, Kansas 66210

Telephone: (913) 451-8550 ♦ Fax: (913) 469-5266

Patient Registration Form - Adolescent

Today's date:		Therapist:				
PATIENT INFORMATION						
Patient's Last Name:		First Name:		Middle Initial:	Birth date: / /	Age:
Street Address:			City:		State:	Zip:
Home Phone: ()		Cell Phone: ()		Sex:		Social Security #:
School:		Grade:	Teacher/Counselor:		School District:	
Referred by: <input type="checkbox"/> Physician <input type="checkbox"/> Family member <input type="checkbox"/> School <input type="checkbox"/> Friend <input type="checkbox"/> Other Name:						
MOTHER'S INFORMATION						
Last Name:		First Name:		Middle Initial:	Birth Date: / /	Social Security #:
Home Phone: ()		Cell Phone: ()		Work Phone: ()		
Street Address:			City:		State:	Zip:
Employer:			City:		State:	Zip:
FATHER'S INFORMATION						
Last Name:		First Name:		Middle Initial:	Birth Date: / /	Social Security #:
Home Phone: ()		Cell Phone: ()		Work Phone: ()		
Street Address:			City:		State:	Zip:
Employer:			City:		State:	Zip:
DIVORCE POLICY						
<p>We recognize that many children live with two separate families. While you and your child's other parent may have an agreement about paying for health-related appointments, we are not able to be an intermediary in that process. The parent who signs the paperwork at the initial visit will be considered the responsible party for all patient balances.</p> <p>Unless you provide us with a court order indicating one parent has sole custody, any information in our possession concerning a minor child will be provided, upon request, to either or both parents.</p> <p>I have read and understand the above stated policies.</p>						
_____ Signature				_____ Date		

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Patient Registration Form – Adolescent (cont'd)

EMERGENCY INFORMATION

Last Name:

First Name:

Relationship to child:

Home Phone:

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Work Phone:

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Cell Phone:

()

FINANCIAL POLICY

All payments will be collected at *check-in* during regular business hours.

Co-pays for patients covered by insurance are due at the time services are rendered. Anytime our receptionist is unavailable, please place your payment in the lockbox to the left of the receiving window in the waiting area, or pay your therapist immediately following your appointment.

If your clinician does not participate with your insurance company, or if you choose not to use your insurance benefits, payment in full is due at the time of service. Upon request, we will provide you with a Visit Summary form to file with your insurance company for reimbursement.

It is your responsibility to obtain prior authorization through your insurance company, if required. Failure to do so may result in out-of-pocket expense.

Your therapist reserves the right to charge you if you fail to notify the office of a cancellation 24 hours prior to your scheduled appointment.

I have read and understand the above stated policies.

Signature

Date

Responsive Centers for Psychology and Learning

Adolescents Name:			Therapist:		
PRIMARY INSURANCE INFORMATION					
Primary Policy holder is: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Neither					
If NEITHER please provide the following information about the primary policy holder:					
Primary Policy Holder Last Name:		First Name:		Middle Initial:	Birth Date: / /
Social Security #:		Street Address:		City:	State: Zip:
Home Phone: ()	Work Phone: ()	Cell phone: ()	Relationship to patient:		
Please complete the following only if you are unable to supply a copy of your card:					
Primary Insurance Company Name:		ID #: Group #:	Phone #: ()		
Street Address:		City:	State:	Zip:	
SECONDARY INSURANCE INFORMATION (if applicable)					
Secondary Policy holder is: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Neither					
If NEITHER please provide the following information about the secondary policy holder:					
Secondary Policy Holder Last Name:		First Name:		Middle Initial:	Birth Date: / /
Social Security #:		Street Address:		City:	State: Zip:
Home Phone: ()	Work Phone: ()	Cell phone: ()	Relationship to patient:		
Please complete the following only if you are unable to supply a copy of your card:					
Secondary Insurance Company Name:		ID #: Group #:	Phone #: ()		
Street Address:		City:	State:	Zip:	
AUTHORIZATION OF PAYMENT					
Please Choose ONE of the following:					
<input type="checkbox"/> The above named adolescent is a private payment patient. I will be responsible for payment in full at the time each service is rendered.					
Signature: _____			Date: _____		
<input type="checkbox"/> I authorize payment of insurance benefits to Responsive Centers for Psychology and Learning, 7501 College Boulevard, Suite 250, Overland Park, KS 66210 for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances unpaid by my insurance company including, but not limited to, deductibles and co-pays.					
Signature: _____			Date: _____		

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BIOGRAPHICAL INFORMATION

This information is to help your psychologist or therapist prepare for your visit and to facilitate treatment planning.

Name: _____ Nick Name: _____ DOB: _____ Age: _____

PRESENTING PROBLEMS

What concerns or problems, including symptoms, convinced you to seek help for your adolescent now? _____

On the scale below please check the severity of the problem(s):

Mildly upsetting Moderately severe Very severe Extremely severe Incapacitating

How long has this been a problem? _____ Has your adolescent been treated for this problem before? _____

If yes, who treated your adolescent? _____

FAMILY INFORMATION

Mother's Name: _____ Phone: _____ Cell: _____

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

Father's Name: _____ Phone: _____ Cell: _____

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

Marital Status of Parents: Married to each other Remarried Divorced Separated Significant other

If parents are separated or divorced, which parent has legal authority to health care decisions: _____

Sibling names and ages: _____

Others living in the home: _____

If parents are divorced or separated please provide the current custody arrangements: _____

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EDUCATIONAL HISTORY

Special education or special needs: yes no If yes, please explain: _____

Has your adolescent ever had psychological and/or educational testing? yes no If yes, please summarize the results:

Does your adolescent have an Individual Education Plan or 504 Plan in place? yes no

Is your adolescent frequently absent from school? yes no If yes, please explain: _____

How would you describe school behavior, grades, and progress? _____

MEDICAL HISTORY

Primary Care Physician: _____ Date of last physical exam : _____

Medical problems your adolescent is being treated for currently: _____

Allergies: _____

Current medications: _____

PSYCHIATRIC HISTORY

Previous mental health treatment? yes no Level of care? Inpatient Partial hospital Outpatient

Reason for treatment: _____

Treating therapist(s)' name(s): _____

Has your adolescent ever attempted suicide? yes no If yes, when: _____

Is your adolescent currently having suicidal ideation? yes no don't know

Does your adolescent have a plan? yes no don't know

Family history of psychiatric problems. Describe: _____

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ALCOHOL/DRUG USE/ABUSE

Abstains Social Episodic abuse Loss of control Use in spite of adverse consequences Recovering

Types of substance(s)? _____

Frequency? _____ Amount? _____

Family member(s) abuse ? yes no If yes, who: _____

LEGAL HISTORY

Has your adolescent ever been arrested? yes no If yes, for what reason and age: _____

SOCIAL HISTORY

Is your adolescent able to make friends? yes no Is your adolescent able to maintain friendships for over a year? yes no

Is your adolescent frequently bullied or severely teased? yes no don't know

Is your adolescent sexually active? yes no don't know

If your adolescent is sexually active, is (s)he using protection? yes no don't know

RELIGION

How strong are your family's religious beliefs or practices? Very Strong Moderate Not Strong NA

Patient's Rights and Responsibilities

Patients have the right to:

- Be treated with professionalism and respect
- Confidentiality (see Notice of Privacy Rights)
- Receive explanations about office procedures, or answers to any questions you may have
- Participate in decisions regarding treatment planning
- Consent to or refuse any treatment

Patients also have the responsibility to:

- Provide information needed by the professional staff to care for you
- Keep all scheduled appointments and be on time, and to cancel at least 24 hours in advance if you are unable to keep an appointment
- Pay your fees, deductibles, and co-payments
- Provide insurance information if you wish to use your insurance benefits

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Report to Primary Care Physician

I authorize **Responsive Centers** to release information to my primary care physician. _____
Patient Signature

Please provide the following information so that we are able to contact your physician.

Patient Name:	Patient DOB:
Patient Social Security Number:	Authorization # (if applicable)
Physician Name:	Physician Phone #:
Physician Address:	Physician Fax #:

I **DO NOT** authorize **Responsive Centers** to release information to my primary care physician. _____
Patient Signature

FOR OFFICE USE ONLY

This is a (n) Initial Summary Interim summary Termination Summary

Suggested Diagnoses

Axis I: _____

Axis II: _____

Psychotropic Medications

Current psychotropic medications: _____

Please evaluate this patient for the appropriateness of medication for the treatment of _____

Treatment Goals

Treatment Modalities Individual therapy Family therapy Group therapy Couples therapy

Psychotropic medication Referral to community resources _____

Psychologist/Therapist Signature Date

Please complete and return if medication is prescribed or changed or if there are any medical conditions or medications that may be causing or contributing to the patient's symptoms of mental disorder.

Medication prescribed: _____ Dose: _____

Medication prescribed: _____ Dose: _____

Physician Signature Date

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CONSENT TO TREAT - ADOLESCENT

What you can expect: The purpose of meeting with a psychologist or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life, including school. You may be here because you wanted to talk to a professional about these problems; or you may be here because your parent, guardian, doctor or teacher had concerns about you. When you meet with your clinician, you will discuss these problems. After listening to your concerns and asking questions, your clinician will suggest a plan for improving these problems. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, the information you share with your therapist in your sessions is confidential, unless you have given your written permission to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information. In some situations, your therapist is required by law or by the guidelines of the profession to disclose information whether or not you give your permission. Some of these situations are listed below:

- You report you plan to cause serious harm or death to yourself, and your therapist believes you have the intent and ability to carry out this threat in the very near future. Steps will be taken to inform a parent or guardian of what you have told and how serious your therapist believes this threat is. Your therapist must make sure that you are protected from harming yourself.
- You tell your therapist you plan to cause serious harm or death to someone else who can be identified, and your therapist believes you have the intent and ability to carry out this threat in the very near future. In this situation, your parent or guardian must be informed as well as the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, your therapist needs to use professional judgment to decide whether a parent or guardian should be informed.
- You tell your therapist you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, your therapist is required by law to report the abuse to the Kansas Department of Social and Rehabilitative Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, your therapist will not disclose information without your written agreement *unless* the court requires it. If your therapist is required to disclose information to the court, you will be informed that this is happening.

Communicating with your parent(s) or guardian(s): Except for situations such as those mentioned above, your therapist will not tell your parent or guardian specific things you share in therapy sessions. This includes activities and behavior that your parent/guardian would not approve of or would be upset by -- but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then your therapist will need to use professional judgment to decide whether you are in serious and immediate danger of being harmed. If your therapist believes that you are in such danger, that information will be communicated to your parent or guardian.

Even if your therapist agreed to keep information confidential-to not tell your parent or guardian- it may be important for them to know what is going on in your life. In these situations, you will be encouraged to tell your parent/guardian and you will be helped to find the best way to tell them. Also, when meeting with your parents, your therapist may sometimes describe the problems you are discussing in general terms, without using specifics, in order to help them know how to be more helpful to you.

School: Information will not be shared with your school unless both you and your parent or guardian provides permission. Sometimes your therapist may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for your therapist to give suggestions to your teacher or counselor at school. A very unlikely situation might come up in which your therapist may not have your permission but both your therapist and your parent or guardian believe that it is very important to be able to share certain information with someone at your school. In this situation, your therapist will use professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and your therapist may need to work together; for example, if you need to take medication in addition to seeing a therapist. Your therapist will get your written permission and permission from your parent or guardian in advance to share information with your doctor. The only time information will be shared with your doctor even without your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Minor's Signature: _____

Date: _____

Parent's Signature: _____

Date: _____

Witness Signature: _____

Date: _____