CHILD/ADOLESCENT INFORMATION SHEET

Date: ___/___/____

PATIENT'S NAME: _____
(First) (Initial) (Last) Birth date:___/___/____
Age: ___ Grade: _____

Patient's Address: _____

City/State/Zip: _____ Home Ph: (____)_____
ZIP

Occupation or school: _____ Cell Ph: (____)_____

Referred by: _____

PERSON RESPONSIBLE FOR BILL:

Name: _____

Address (or "same"): _____

City/State/Zip: _____

- **I authorize the release of any medical information necessary to process insurance claims.**
- I authorize payment of benefits to Dr. Schenk if full payment is not made at the time of service.
- I understand that I am responsible for missed appointment charges (one-half of the full fee for the session) unless Dr. Schenk is notified 24 hours in advance.
- I understand that I am responsible for all services rendered. In the event that payment is not made at the time service is rendered, then I agree to pay my account balance in full within 30 days of the billing date. If timely payment is not made, I agree that I am responsible for all costs of collection, including court costs and reasonable attorney's fees.
- I understand that interest will be charged on outstanding balances more than 60 days old at the rate of 1.5% per month.
- I understand that the insurance company may refuse to pay a claim even if it authorizes services such as psychological testing. Non-covered services are billed at my full fee.

SIGNED_____ Date: ____/____/_____

INSURANCE INFORMATION: (if applicable) ***Please*** *check your policy to determine if preauthorization is needed.*
Please note: *Claims for services will be sent to your insurance company each month unless you specifically instruct otherwise*.

Name and address of policy holder (or "same"):

_____

_____

Insurance Company Name:_____ Ph #: (____) _____

Address:_____

City/State/Zip:_____

Member (ID) #:_____ Group #:_____ D.O.B. ___/___/_____

Employer:_____
Patient's Relationship to policy holder:
[ ]Self [ ]Spouse [ ]Child [ ]Other

If you have insurance coverage with two insurance companies, please list the policy information for the *secondary* policy below:

Name and address of policy holder (or "same"):

_____

_____

Insurance Company Name:_____ Ph #: (____) _____

Address:_____

City/State/Zip:_____

Member (ID) #:_____ Group #:_____ D.O.B. ___/___/_____

Employer:_____
Patient's Relationship to policy holder:
[ ]Self [ ]Spouse [ ]Child [ ]Other

I have read [ ] initial and/or received [ ] initial a copy of the HIPAA notice regarding Dr. Schenk's office policies and practices to protect my health information. Available at: http://www.drpaulschenk.com/forms/HIPAA.PDF

_____ Date: ____/____/_____
Signature

CHILD AND ADOLESCENT QUESTIONNAIRE

Date _____

Completed by _____

Background Information

Mother's Name: _____

Address: _____
or "same"

_____

Occupation: _____ Educational level: _____

Single __; Married __; Divorced __; Remarried__; Partnered___; Widowed __

Please put a " ✓ " In the boxes below if it okay for me to leave a message at this number/email

Home Ph: (____)_____ □ Cell Ph: (____)_____ □

Work Ph: (____)_____ □ Fax: (____)_____ □

E-mail: _____ □

Father's Name: _____

Address: _____
or "same"

_____

Occupation: _____ Educational level: _____

Single __; Married __; Divorced __; Remarried__; Partnered___; Widowed __

Please put a " ✓ " In the boxes below if it okay for me to leave a message at this number/email

Home Ph: (____)_____ □ Cell Ph: (____)_____ □

Work Ph: (____)_____ □ Fax: (____)_____ □

E-mail: _____ □

Please use this page to provide information about step-parents, partners, or other parental figures. If the birth parents are separated/divorced, please provide contact information for the other parent if you want me to have it.

Name: _____

Address: _____

or "same" _____

Occupation: _____ Educational level: _____

Single __; Married __; Divorced __; Remarried__; Partnered___; Widowed __

Relationship to the child/teen: _____

Please put a " ✓ " In the boxes below if it okay for me to leave a message at this number/email

Home Ph: (____)_____ □ Cell Ph: (____)_____ □

Work Ph: (____)_____ □ Fax: (____)_____ □

E-mail: _____ □

Name: _____

Address: _____

or "same"

_____

Occupation: _____ Educational level: _____

Single __; Married __; Divorced __; Remarried__; Partnered___; Widowed __

Relationship to the child/teen: _____

Please put a " ✓ " In the boxes below if it okay for me to leave a message at this number/email

Home Ph: (____)_____ □ Cell Ph: (____)_____ □

Work Ph: (____)_____ □ Fax: (____)_____ □

E-mail: _____ □

Referral Information

Your answers to the three sections on this page are very important. If this is an evaluation to rule out a learning problem or other issue such as ADHD, please list specific questions for which answers are sought. If you are coming for individual and/or family therapy for your child/teen, please use the first section to tell me your reason(s) for requesting my services. Use the second section to describe ways you want your child/teen's life to have changed for the better when we *finish* working together. Then use the third section to tell me about areas in your child/teen's life where you are generally pleased about how things are *already* working.

Language spoken in the home if not English: _____

List all people now living in the household, then draw a line and list others who have lived with the child (please note dates):

Name	Relationship to Child	Age	Highest School Grade Attended	Occupation
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

Please indicate if any children in the household were adopted and dates of any previous marriages, divorces, remarriages of parents. Describe custody arrangements. Describe any deaths in the immediate family. Note any unusual family circumstances.

_____

_____

_____

_____

_____

_____

Pediatrician _____

Address _____

_____

Telephone _____

Permission to talk to pediatrician? Yes _____ (Please initial if yes)
No _____

Pregnancy and Birth History

Describe any complications that occurred during pregnancy.

_____

_____

_____

Describe any complications that occurred during delivery (e.g., prematurity, postmaturity, length of labor, special procedures, etc.).

_____

_____

_____ Birth Weight _____

How long after birth did you take your baby home? _____

Early Temperament

Describe the child's temperament during the first six months (i.e., sleep patterns, colic, eating patterns).

_____

_____

_____

Developmental History

Note the approximate ages of the following:

Toileting	_____	Sitting unsupported	_____
Urine daytime	_____	Walking alone	_____
Urine nighttime	_____	Using single words	_____
Bowel daytime	_____	Using two or more	
Bowel nighttime	_____	words together	_____

Which hand does your child prefer? Right _____ Left _____ Age established _____

Medical History

List sicknesses (e.g., frequent ear infections), operations, and injuries. Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsing, or very high fever.

_____

_____

_____

_____

Did anyone in your immediate family or their close relative have any of the following:

Nervous tics	Yes ____	No ____	Who _____
Seizures (epilepsy)	Yes ____	No ____	Who _____
Emotional problems	Yes ____	No ____	Who _____
Hyperactivity	Yes ____	No ____	Who _____
Learning problems	Yes ____	No ____	Who _____
Language problems	Yes ____	No ____	Who _____
Mental retardation	Yes ____	No ____	Who _____
Similar problems to child	Yes ____	No ____	Who _____

Does any disease run in the family? If so, what? _____

Indicate any medications your child is *currently* taking and prescribing physician (include dosage and reason for taking).

Name of medication/dose/frequency Physician

_____ _____

_____ _____

_____ _____

Indicate any medication your child has taken *in the past for more than a month* and prescribing physician (indicate dosage and reason it was taken.

_____ _____

_____ _____

_____ _____

_____ _____

Has your child's vision been examined? _____ Date _____

If so, by whom? _____

Results _____

Has your child's hearing been examined? _____ Date _____

If so, by whom? _____

Results _____

Other special medical tests (EEG, CAT scan, MRI)

Name of Test _____ Date _____

Results _____

Have there been any previous psychological, psychiatric or neurological evaluations? If so, please list names, addresses and dates of contact. *Please attach any pertinent reports.*

_____

_____

Social/Emotional/Behavioral History

List your child's personality characteristics, both positive and negative:

_____

_____

_____

Note any particular behavioral concerns (i.e., eating habits, sleeping patterns, level of activity, sibling relationships, peer relationships, moodiness, attending difficulties, destructiveness, unusual habits, fears, tenseness, etc.)

_____

_____

_____

Current discipline techniques: _____

_____

Who disciplines? _____

Do parents agree on how to discipline? _____

How does your child respond to discipline? _____

_____

School History

List previous schools attended with dates (include nursery school and preschool):

_____

_____

List current subjects taught:

_____ _____ _____ _____

_____ _____ _____ _____

Permission to talk to teachers and other school personnel? _____

If yes, please initial:_____

Describe any learning/behavioral/social difficulties at school:

_____

_____

_____

_____

Has your child received any special services in school (resource room, tutors, remedial reading, speech, etc.)?

Date Placed _____ How often? _____

Has your child received any special services privately? _____

Name _____ Phone # _____

Date begun _____

Describe services, how often seen, length of time:

_____

_____

Has your child ever repeated a grade? _____ When? _____

What was the problem? _____

_____

List the grades from most recent report card or attach a copy.

_____

_____

_____

Do you wish a report of findings to be sent to a physician, school, or other child agency? If so, to whom?

_____

_____

_____

_____

I very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments below.

- ***Please bring a photograph of the family so I may make a copy for my file.***
- *Please also bring copies of* ***report cards*** *and any* ***prior achievement testing*** *the school may have done.*
- *If I will be doing a psychoeducational evaluation, please bring a good sample of your child's work. I would like to see samples of writing (especially paragraphs if your child is old enough), math work, drawings, etc. The more you can bring the better.*

Signature of person completing the form: _____

Additional notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Behavior Checklist

Cluster A

Yes	No		
			Aggression to people and animals
[ ]	[ ]	1.	often bullies, threatens, or intimidates others
[ ]	[ ]	2.	often initiates physical fights
[ ]	[ ]	3.	has used a weapon that can cause serious physical harm to others (e.g., bat, brick, broken bottle, knife, gun)
[ ]	[ ]	4.	has been physically cruel to people
[ ]	[ ]	5.	has been physically cruel to animals
[ ]	[ ]	6.	has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
[ ]	[ ]	7.	has forced someone into sexual activity
			Destruction of property
[ ]	[ ]	8.	has deliberately engaged in fire setting with the intention of causing serious damage
[ ]	[ ]	9.	has deliberately destroyed others' property (other than by fire setting)
			Deceitfulness or theft
[ ]	[ ]	10.	has broken into someone else's house, building or car
[ ]	[ ]	11.	often lies to obtain goods or favors or to avoid obligations (i.e., "con" others)
[ ]	[ ]	12.	has stolen items of nontrivial value without confronting a victim (shoplifting, but without breaking and entering; forgery)
			Serious violations of rules
[ ]	[ ]	13.	often stays out at night despite parental prohibitions, beginning before age 13
[ ]	[ ]	14.	has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
[ ]	[ ]	15.	is often truant from school, beginning before age 13 (for older person, absent from work)

Cluster B

[ ]	[ ]	1.	often loses temper
[ ]	[ ]	2.	often argues with adults
[ ]	[ ]	3.	often actively defies or refuses adult requests or rules, e.g., refuses to do chores at home
[ ]	[ ]	4.	often deliberately does things that annoy other people, e.g., grabs other children's hats
[ ]	[ ]	5.	often blames others for his or her own mistakes or misbehavior
[ ]	[ ]	6.	is often touchy or easily annoyed by others
[ ]	[ ]	7.	is often angry and resentful
[ ]	[ ]	8.	is often spiteful or vindictive

Insurance Benefits Worksheet

This worksheet is designed to help you get the most from your insurance policy. I invite you to grab a pen, your favorite beverage and a phone and call your carrier after you read through these helpful tips. Many insurance companies now require pre-authorization for mental/behavioral health services. Those that do rarely back date an authorization, so please call your carrier before your first appointment to be sure. Some insurance companies now use a "third party administrator" or TPA to handle mental/behavioral health benefits. Note: If there is a secondary insurance carrier, Georgia law dictates that the insurance of the policy holder with the earlier birth date (the birth month, not the birth year) will be the primary policy.

Unfortunately, I find it often takes several phone calls to get to the person at the insurance company who can answer the questions.

1st #: (_____) _____ - _____ Name of Person Contacted:_____
2nd #: (_____) _____ - _____ Name of Person Contacted:_____
3rd #: (_____) _____ - _____ Name of Person Contacted:_____
Policy Holder's Name: _____
Date of Birth: _____/_____/_____
Policy Holder's ID#: _____
Group#: _____
Please confirm the name and address for mailing mental health claims. It is usually ***not*** the address on the insurance card.
Insurance Company Name: _____
Address: _____
_____
City: _____ State: ___ Zip Code:_____

The insurance company will need to know my name, my zip code (30345), my tax id# (58-1477829), and that I am an “out of network” provider (except for Medicare, Medicaid, Wellcare, Ambetter/Cenpatico and Tricare). Some policies do not cover any out of network services; some have a different deductible. Be sure to ask.

A full evaluation for ADHD or learning problems in a child or teen typically requires seven hours of psychological testing, plus three additional hours for the report preparation. The CPT code for these hours is 96101. Please note that in recent years, most insurance companies will not pay for testing to rule out learning problems, because your tax dollars pay for the public school system to perform such testing (even if your child attends a private school). Similarly, an increasing number of insurance companies have stopped paying for psychotherapy for treating ADHD. They will pay only for the diagnosis. If I am going to be evaluating your child or teen for learning problems and/or ADHD, please be sure we discuss billing and insurance issues before the first appointment.

Is pre-authorization required for mental/behavioral health visits? [ ] yes; [ ] no
If "yes", ask for the authorization # for the initial visit: _____
Authorization # for subsequent visits (if provided): _____
The number of additional visits approved with this authorization: _____

Is a separate pre-authorization required for testing? [ ] yes; [ ] no
If "yes", I will probably have to submit a formal request justifying why the testing is needed. The form I will have to complete is on the insurance carrier’s web site if you wish to look at it ahead of time.

Please be sure you have read the web page: Psychological Testing for Children and Teens.

Is there a separate mental/behavioral health deductible for the policy? [ ] yes; [ ] no
If "yes", how much is it? $_____ How much has already been met? $_____
If "no", how much is the medical deductible? $_____ How much has already been met? $_____
Is the deductible different for services provided by an "out of network" provider? [ ] yes; amount: ____; [ ] no
Is your deductible based on a calendar year [ ] or on a different 12 month period? ____to ____

Getting the insurance company to tell you its Usual and Customary Rate ("UCR" or the "allowed" rate that participating providers can charge) is a real challenge. Use this list to record the UCR the insurance company will consider for these services:

CPT Code	Type of Session	Fee Schedule: Amount Allowed
CPT code 90791	Diagnostic Interview (60 minutes)	$_____ out of $200
CPT code 90834	Individual Psychotherapy (45 minutes)	$_____ out of $170
CPT code 90837	Individual Psychotherapy (60 minutes)	$_____ out of $200
CPT code 90847	Family Psychotherapy (60 minutes) Note: Some policies will not pay for family psychotherapy.	$_____ out of $200
CPT code 96101	Psychological Testing/Evaluation (per 55 minute hour)	$_____ out of $200

For psych testing, I strongly recommend you ask a question of this type:
Will the policy consider psychological testing (CPT billing code 96101) to be a "covered expense" ***if*** the ***only diagnosis*** that results from the testing is one of the following?
[ ] yes [ ] no 314.00 Attention Deficit Hyperactivity Disorder
[ ] yes [ ] no 315.0 Reading Disorder (or variants such as 315.01, 315.02, 315.09)
[ ] yes [ ] no 315.1 Specific Arithmetical Disorder
[ ] yes [ ] no 315.2 Other Specific Learning Difficulty
[ ] yes [ ] no 315.3 Developmental Speech or Language Disorder (or variants such as 315.2x)
[ ] yes [ ] no 315.9 Learning Disorder, Not Otherwise Specified

What is the co-payment for psychotherapy (90837)? $_____.
Remember, if they tell you they will pay 80%, leaving you with a co-payment of 20%, ask, "*20% of what*?"
Their reimbursement rate will be based on the allowed amount, which may be less than my rate.
Some policies vary the co-payment after a certain # of sessions. If your does, please list the specifics below:

_____
Maximum visits per year: _____ [ ] Calendar year or [ ] year begins on ___/___

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