Shelby Psychological Services

Adolescent Patient Registration Form

PATIENT INFORMATION

Name	Birth Date	❒ Male ❒ Female	Social Security Number
Street Address	City	State	Zip Code
School	Grade	Patient /Guardian Employer	Work Phone ( )
Responsible Party's Email Address			Home Phone ( )
Primary Care Physician Name:			Cell Phone ( )

How Did you Hear About Us?

❒ Physician ❒ Internet ❒ Yellow Pages ❒ Insurance Co. ❒ Other _____

INSURANCE INFORMATION (Please provide your insurance card for office to copy)

Primary Insurance	Policy Holder's Name		
Policy Holder's Social Security #	Birth Date	Employer	Group number
Policy Number	Patient's Relationship to Policy Holder		
Secondary Insurance			
Policy Holder's Name	Birth Date	Employer	Group number
Policy Number	Patient's Relationship to Policy Holder		
Person Responsible for Bill and address if different			

Your Signature

Acknowledges:

- Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
- Notice of HIPPA and State of Alabama policy and practices to protect your health information
- Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services (SPS)
- Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog

Authorizes:

- SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
- Consent to release treatment information to SPS providers only in the event of an interoffice referral
- Consent to release requested information to the referring physician/source
- Consent to release information for insurance purposes, when required, with supervising providers

I have read, understand and acknowledge/authorize the above.

_____	_____	_____
Signature of Patient (if age 14 & older)	Printed Name of Patient	Date
_____	_____	_____
Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date

CHILD PATIENT INFORMATION

(To be completed if the patient is 18 years or younger)

Child's Full Name: _____
Child is called:_____
Present School: _____ Grade:_____
Does your child receive any special education services? _____
If yes, please describe: _____
Has your child repeated a grade? _____
If yes, please describe: _____
Has your child been involved the legal system? _____
If yes, please describe: _____
_____
Primary Care Physician/Pediatrician Name: _____
Phone: _____ Address:
_____
May I contact him/her regarding your child's care? Yes_____ No _____

Is your child adopted? _____ If yes, at what age: _____
Child's biological or adopted parents are:
__living together __separated __divorced
__father deceased __mother deceased __father remarried __mother remarried
Biological/Adopted Father's Full Name:_____
Address: _____
Biological/Adopted Mother's Full Name: _____
Address:_____
Stepfather's Full Name: _____
Stepmother's Full Name: _____
The child lives with: _____Relationship to child: _____
(If applicable) Child is in Legal Custody of: _____
_____joint or _____full
(please have the front desk staff make a copy of the custody papers)
Siblings:

Names	Age	Full/Half/Step	Grade

Brief statement of your concerns and goals for treatment:

Shelby Psychological Services
FINANCIAL AGREEMENT

Patient/Guardian/Responsible Party Name:
_____

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. **APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE.** Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of $200/hour. A retainer fee of $1000 is required at the time of the request. _____Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____Date _____

PROMIS–29 Profile v1.0

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
PFA11 1	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21 2	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA23 3	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53 4	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDANX01 5	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40 6	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41 7	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53 8	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDDEP04 9	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP06 10	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29 11	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41 12	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
HI7 13	I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
A3 14	I have trouble <u>starting</u> things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	In the past 7 days…					
FATEXP41 15	How run-down did you feel on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS–29 Profile v1.0

Fatigue

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
FATEXP40 16	How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
Sleep109 17	My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
Sleep116 18	My sleep was refreshing	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep20 19	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep44 20	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Satisfaction with Social Role

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
SRPSAT07 21	I am satisfied with how much work I can do (include work at home)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT24 22	I am satisfied with my ability to work (include work at home)……	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT47 23	I am satisfied with my ability to do regular personal and household responsibilities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SRPSAT49 24	I am satisfied with my ability to perform my daily routines	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9 25	How much did pain interfere with your day to day activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ22 26	How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ31 27	How much did pain interfere with your ability to participate in social activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ34 28	How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Intensity

	In the past 7 days…											
Global07 29	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

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**
☐	☐	☐	☐

Treatment Agreement

The purpose of this document is for you and your parents/guardian to understand how therapy works and for us to agree on our roles. My role is to complete an evaluation and offer appropriate recommendations and treatment. Your role is to be honest in your answers to questions and to participate in the process with open discussions about your thoughts, feelings and behaviors. Your parents' role is to be supportive but not intrusive, make sure that you are at your appointments, deal with the financial part of treatment, to give me information that they think is important for me to know, and to participate in family sessions as needed.

Therapy
It usually works this way:

- Three sessions for the evaluation – this may include some testing.
- I will give feedback from my assessment and make my recommendations, first to you and then (in front of you) to your parents.
- If therapy is recommended, you and I will decide on the goals/things you would like to work on. We may have some family sessions where specific problems are addressed.

Confidentiality
When you come to therapy, our discussions are held in confidence. However, there are limits to what I can keep secret from your parents. Basically, your parents will be told about things that threaten your immediate safety. I will alert them if:

- I am concerned that you will attempt to harm/kill yourself
- I am concerned that you are a physical threat to harm someone else
- I learn that you are being abused by anyone. (I am required by law to report this to DHR as well.)
- You need more treatment than I can provide (i.e. need medication or hospitalization).

Your parents understand that if I tell them all the things you do, you would likely not be open with me. That would of course, limit how helpful I can be to you. I call behaviors that can be dangerous but do not threaten your immediate safety *gray zone behaviors*. I may or may not choose to alert your parents about these. These could include things such as:

- Drug and/or alcohol use
- High risk sexual behavior
- Gang related activities

Under circumstances such as these I will discuss with you my concerns and we will decide together how to inform your parents. Ultimately, it will be my decision whether I think your safety is in danger enough to break your confidence and tell them.

My records about your treatment are considered "privileged". By Alabama law if you are 14 years or older they cannot be shared with anyone without your written permission. Your parents have however, signed on the intake forms that I can provide the basic information to your insurance company in order to get paid. I also am required to provide your file to the courts, with or without your permission, if I receive a court order signed by a judge.

Ways to Contact Me
I do not have an on-call service. Sometimes, though, you may wish to talk or tell me something, but it is not an emergency (although it may seem urgent). Other times, you may want me to know things but know you will forget by the next time we meet.

- You can phone me and leave a message (205-664-4010)
- You can email me (gbvance@shelbypsych.com)

However, you should know that any content you send in this manner may not be completely secure or confidential. I keep a record of all our email communications in your file. If you choose to communicate by email, be aware that all emails are retained in the logs of your and our Internet Service Providers. Please review our social media policy for more information on this.

It is my policy to not give my personal information to clients. This includes my cell number, friending on Facebook or other social media etc. That said, I understand that you may want to connect with me during

a time of crisis. SPS and my policy is to be available during the work hours (may need to leave a message if I'm in session). Our staff can get me a message quickly. After hours needs to be handled by a safety plan we may have in place. The National Crisis Hotline - 1-800-273-TALK (1-800-273-8255) and specific Alabama crisis lines The Crisis Center (Central Alabama) Main Line: (205) 323-7777 and Teen Line: (205) 328-LINK (205-328-5465) are also available to you. Calling the police for assistance, going to the emergency room are also avenues for you should I be immediately unavailable.

More About Confidentiality
It is your parents' role to pay the bills and to make sure you get to your sessions. You may drive yourself and not be accompanied by either of your parents or other adult. I will have you sign that you were in fact present. If you do not come, and you usually drive yourself, I will call your parents and let them know that you did not show up. In this way, I can check to make sure that you are okay and your parents will not be surprised when they get billed for you not coming.

Because I live in the same area as many of you, I may see you out and about. My general rule is to let you approach me first rather than putting you in position of having to explain who I am with someone you might not want to tell.

Rules of Play
I ask that you abide by basic rules of play with me and your parents. They are:

- Stay Safe
- Show Respect
- Keep in Touch

Your Responsibilities in Treatment
It is important that you are an active participant in your own treatment. I ask that you agree to be involved by:

1. Attending sessions (or letting me know when you can't make it 24 hours in advance)
2. Be actively involved during sessions
3. Voicing your opinions, thoughts and feelings honestly and openly (positive or negative)
4. Completing any assignments I may give (not like school I promise!)
5. Experiment with new ways of doing things (see #4)
6. Take medication if and as prescribed
7. Implement a Crisis Response Plan (if/when needed)

Agreement
I understand that Dr. Vance has a small therapy dog that is often in session. I agree that I will alert her should I wish NOT to interact with him and that this will in no way negatively affect the treatment I receive at SPS. I have read and understood all of the above and agree to participate within these guidelines.

_____	_____
Patient	Date
_____	_____
Parent/Guardian	Date
_____	_____
Parent/Guardian	Date
_____	_____
Gaye B. Vance, Ph.D.	Date