Dr Dean & Associates

Date_____

Name_____**Gender**_____
FIRST MIDDLE LAST

Perferred name_____

DOB _____/_____/_____**Social Security #** _____

Address_____ **City**_____**State** _____ **Zip**_____

P.O. Box _____

Home Phone (_____) _____-_____ **Cell Phone** (_____)_____-_____

E-mail Address_____@_____

Patient Race: White/Caucasian (3) Black (2) Hispanic (4)

Asian/Pacific Islander (1) American Indian/Alaskan Native (5) Multi-racial (**10)**

Father's Name:_____**DOB**_____/_____/_____
FIRST MI LAST

SSN: _____ **Phone Number**:_____

Address/City/State/Zip:_____

Employer: _____**Work Phone**:_____

Mother's Name:_____DOB_____/_____/_____
FIRST MI LAST

SSN: _____ **Phone Number**:_____

Address/City/State/Zip:_____

Employer: _____**Work Phone:**_____

Guardians Name_____

Insurance Co._____**Policy#**_____

Policyholder's Name_____ **DOB:** _____ **SSN**:_____ **Self Spouse**

Referring Doctor _____**Family Physician**_____

Preferred Pharmacy: _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED FOR OFFICE PROCEDURES.

PO Box 5427
Sioux City, Iowa 51102

CHILD CLINICAL INTAKE ASSESSMENT
DEAN & ASSOCIATES

Phone: 712-274-6729
Fax: 712-274-6744

Patient Name: **Age/DOB:** **Date**:

Address:

Current Grade/School: **On IEP?:**

Religious Preference: _____

Full name and relationship of person filling out form: _____

List Parents, brothers and sisters as well as others living in the home (Specify whether full, half, step or foster):

First Name Last Name	Sex	Age	Occupation or School Grade	Address (if different from above)	Relationship to child
Father:					❑Biological ❑Step ❑Foster
Mother:					❑Biological ❑Step ❑Foster
					❑Full ❑Half ❑Not ❑Step ❑Foster Related
					❑Full ❑Half ❑Not ❑Step ❑Foster Related
					❑Full ❑Half ❑Not ❑Step ❑Foster Related
					❑Full ❑Half ❑Not ❑Step ❑Foster Related
					❑Full ❑Half ❑Not ❑Step ❑Foster Related

Is Child Adopted? ☐Yes ☐No **Child's age at Adoption:**

Reason for Referral:

Who referred you to this facility?

What behaviors are your child exhibiting that is of concern to you?

Have others expressed concern about your child (i.e. friends, school, police)? ❑ No ❑ Yes **Describe:**

Medical History (dates/type)
Current Medications and why prescribed:

_____

_____

_____

Allergies

Physical Health

Disabilities/Limitations: _____

Hospitalizations: _____

Surgeries: _____

Mental Health
Counseling: _____

Psychotherapy: _____

Hospitalizations: _____

Problems (past/present)

Has your Child Had:

Head injuries? ❑ No ❑ Yes Describe: _____

Seizures? ❑ No ❑ Yes Describe: _____

Abnormal motor movements or twitches? ❑ No ❑ Yes Describe: _____

Has your child had difficulties in:

Eating? ❑ No ❑ Yes Describe: _____

Sleeping? ❑ No ❑ Yes Describe: _____

Speaking? ❑ No ❑ Yes Describe: _____

Menstruating? ❑ No ❑ Yes Describe: _____

How long have these problems existed? _____

Has your child received treatment previously? ❑ No ❑ Yes
Where?

_____

_____

Legal: _____

_____

_____

Does anyone in your family have a history or problems with:

❑ No ❑ Yes Drug Abuse: _____

❑ No ❑ Yes Alcohol Problems: _____

❑ No ❑ Yes Eating Disorder: _____

❑ No ❑ Yes Depression: _____

❑ No ❑ Yes Gambling: _____

❑ No ❑ Yes Nicotine: _____

❑ No ❑ Yes Caffeine: _____

❑ No ❑ Yes Hospitalized for psychiatric/substance abuse reasons: _____

❑ No ❑ Yes Threatened or attempted suicide: _____

Please explain and give names of any medications they are receiving: _____

Has anyone in your family had thyroid problems? ❑ No ❑ Yes

Relationship to patient: _____

Important recent events in your life: _____

Goals from Treatment/Medication Management: _____

Is there any other information you can think of that might pertain to your child's problems or might help us in understanding him/her better?

_____

_____

_____

_____

_____

_____

_____

_____

SCREENING TOOL
CHECK IF YES TO ANY OF THE FOLLOWING CURRENT PROBLEMS

- ☐ Problem paying attention
- ☐ Unable to work quietly at home
- ☐ Unable to work quietly at school
- ☐ Difficulty concentrating,
- ☐ Difficulty finishing tasks
- ☐ Requires lots of supervision
- ☐ Often disobeys parent or teacher
- ☐ Often fidgets/always on the go
- ☐ Difficulty getting along with other children
- ☐ Impulsive - acts without thinking
- ☐ Gets into fights
- ☐ Lies frequently
- ☐ Runs away
- ☐ Truant from school
- ☐ Takes things that don't belong to him/her
- ☐ Plays with matches/sets fires
- ☐ Cruelty to animals
- ☐ Cruelty to others
- ☐ Fails to take responsibility for own behavior
- ☐ Often loses temper
- ☐ Often argues with adults/authority figures
- ☐ Often does not follow rules
- ☐ Rebellious
- ☐ Swears/uses obscene language
- ☐ Often blames others for his/her mistakes
- ☐ Loss of interest in activities
- ☐ Decreased energy
- ☐ Significant weight loss/gain
- ☐ Cannot be cheered up
- ☐ Sleeping too little/too much
- ☐ Down on self/worthless/guilty
- ☐ Unable to have fun
- ☐ Withdrawal from parents
- ☐ Withdrawal from friends
- ☐ Change from school performance
- ☐ Sensitive to rejection
- ☐ Complains a lot about stomach aches/headaches
- ☐ Wishes he/she was not there.
- ☐ "I wish I was dead." "You'd be better off without me, if I was gone."
- ☐ Any self-destructive acts such as cutting, scratching, or picking
- ☐ Overdose
- ☐ Physically aggressive
- ☐ Verbally aggressive and threatening
- ☐ Destructive to property or objects
- ☐ Fearful of school
- ☐ Fearful of the dark
- ☐ Fearful of strangers
- ☐ Fearful of animals
- ☐ Fearful of public speaking
- ☐ Fearful of leaving home
- ☐ Other fears _____ ___
- ☐ Worry about something happening to him/her
- ☐ Afraid of being apart from you
- ☐ Extremely shy
- ☐ Worry about things before they happen
- ☐ Perfectionist
- ☐ Re-occurring thoughts, acts, or images
- ☐ Doing the same thing over and over again
- ☐ Hoarding
- ☐ Checking over and over
- ☐ Frequently washes hands
- ☐ Excessive fear of germs
- ☐ Alcohol or drug abuse
- ☐ Any known or suspected physical or sexual abuse
- ☐ Any sexual play or acting out - touching of self or others
- ☐ Nightmares
- ☐ Hearing voices (auditory hallucinations)
- ☐ Seeing object/persons others do not see (visual hallucinations)

PATIENT/CLIENT'S INFORMED CONSENT

I have chosen to receive treatment services under Dean & Associates. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist and myself and I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will he upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about myself will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self and others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that information necessary for supervision or consultation may be disclosed.

Transfer Plan: I understand that in the unlikely event that one of our providers is unable to provide ongoing services, another provider at Dean and Associates will provide those services or will refer you to the appropriate resource. Dean and Associates will maintain your records for a period of (7) years. Should Dean and Associates no longer be able to provide ongoing services _____will provide these services or refer you to the appropriate resource. _____ will maintain your records for a period of _____years. _____may be contacted at _____.

Emergency Situations: In the event of a psychiatric emergency I understand that I can call this office at 712-276-6729, and if it is after business hours, the phone message will direct you to call the doctor “on call: and provide you with the appropriate phone number. I understand that I can also go to the nearest emergency room or call 911 if needed.

I have read and had explained to me the basic rights of individuals. These rights include:

l. The right to be informed of the various steps and activities involved in receiving services including medication.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. If I do not revoke this consent, it will expire automatically one year after all claims for treatment: have been paid as provided in the benefit plan.

I have read and understand the above.

_____ _____

Patient/Client Signature **Date**

_____ _____

Parent, Guardian, Conservator or Authorized Representative (When required) **Date**

Dean & Associates
3549 Southern Hills Drive
Sioux City, Iowa 51106
(712) 274-6729

Authorization, Consent & Acknowledgement

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Dean and Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Dean and Associates.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dean and Associates is not required to agree to the restrictions that I may request. However, if Dean and Associates agrees to a restriction that I request, the restriction is binding on Dean and Associates. I have the right to revoke this consent, in writing, at any time, except to the extent that Dean and Associates has taken action in reliance on this consent.

I have reviewed your *Notice of Patient Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Patient Privacy Practices* from time to time and that I may contact Dean and Associates at any time at the address above to obtain a current copy of the *Notice of Patient Privacy Practices.*

Coordination of treatment:

- ☐ I give permission for my provider at Dean and Associates to release mental health information for the purpose of coordination of care with my primary care physician and any other medical practitioners who provide care for me. (If you check this box, please complete included release of information).
- ☐ I decline to release information to my primary care physician or other medical providers at this time.

Advance Directives

- ☐ I currently have a Psychiatric Advance Directive.
- ☐ I do not have a Psychiatric Advance Directive. I understand I can follow-up on this option by logging on to www.nrc-pad.org. It is recommended that you seek legal counsel when completing this document. If such a document is completed, I will provide a copy to this office.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

DEAN & ASSOCIATES

PO BOX 5427, SIOUX CITY, IOWA 51102
PHONE (712) 274-6729 FAX (712) 274-6744

OFFICE POLICY

It is Dean & Associate's policy that payment is made at time of service. We will accept cash, checks or credit cards. You may make payment when checking in if this is convenient, or at the end of your visit. **Be sure to stop at the front desk to make payment, schedule your next appointment and address any concerns**. Payment at time of service cuts down on the cost of billing which results in savings that allows us to keep down the cost of patient care. We do not discriminate based upon race, color, national origin, disability, religion, sex, age or sexual orientation. If you are unable to pay you will not be denied access to our services.

We will be happy to file your insurance claim. We accept most commercial insurances, Medicare and Medicaid. **All patients covered by Insurance must bring their card with them for each appointment.** Please present your card when checking in with the receptionist so we can file your insurance correctly. You are responsible for any remaining balance.

Patients with financial concerns may discuss options with the office manager, patient account representative or their clinician. To qualify for assistance an application for a sliding fee scale will be given per individual or household. For unpaid balances, we do use a collection agency. The guarantor of the account is responsible for any collection fee charged to collect the debt owed. A copy of the fee schedule is available by request at the front desk.

To best serve our clients if you cannot keep your appointment we ask for a 24-hour advance notice of cancellations. You will be charged a fee for a No Show. It is your responsibility as your insurance company does not reimburse for no shows. If you have concerns about this fee or your ability to pay please consult directly with your clinician. You must make your payment for missed appointments, before your next appointment. Parents/guardians are responsible for charges incurred by their minor child.

After 2 "NO **SHOWS",** it will be up to the discretion of your clinician to continue care through this clinic.

Parents/Guardian/Foster Parent or **other responsible adult must be present when a child is being seen.**

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS SET FORTH ABOVE.

_____ _____

Patient or Responsible Person Date