PRIMARY CARE PSYCHOLOGY ASSOCIATES LLC
Adult and Pediatric Psychology

400 SKOKIE BLVD, SUITE 245
NORTHBROOK, IL, 60062
847.686.0090 Phone or Fax

Welcome to Primary Care Psychology Associates! We are looking forward to meeting with you and your child or teen. Before your first appointment, we ask that you complete these forms and either bring them with you to your first appointment or email them to your child/teen's clinician. These forms can be completed and signed electronically by typing within the document. If you have any questions, please contact your child/teen's clinician at 847-686-0090. We look forward to working with you and your family.

Patient Information:

Child/Teen's Full Name (as it appears on the insurance card):_____

Preferred Name:_____Date of birth:_____

Primary Care Physician (PCP): _____

Referred by (if different that PCP): _____

Printed Name of Parent/Guardian Completing This Paperwork: _____

Consent for Services: By signing below, I agree for my child/teen to receive services from the assigned clinician(s) at Primary Care Psychology Associates, LLC (PCPA). Per PCPA policies, both parents are required to sign when parents are not legally married and it is legally determined that both parents are responsible for health-related decisions, formally known as joint custody.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

HIPAA: Please sign below stating that you are aware PCPA follows all requirements outlined by HIPAA. A copy of the full HIPAA policy was provided with the email confirming your first appointment and is also available on our website at www.pcpachicago.com/formspaperwork.html.

_____ _____
Parent/Guardian Signature Date

Consent for Sending Statement of Account for Services by E-Mail:

Email Address:_____

☐ Please check box if you would like an email reminder for sessions.

I consent to have an e-statement sent to my email address for services rendered by Primary Care Psychology Associates, LLC. I also consent for scheduling and logistical information to be sent to my email address. The email address is private and not shared or accessible by any other person than myself. I understand that email is not a totally secure medium.

_____ _____
Parent/Guardian Signature Date

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Payment Agreement

PCPA requires that all patients keep a valid credit or debit card on file. For therapy services, your copay, all current account balances, and any fee-for-service charges will be automatically charged on the credit or debit card on file at each appointment. For testing services, the credit or debit card on file will automatically be charged either the fee-for-services amount or estimated out-of-pocket expenses at each appointment. If your chart is considered closed (see treatment guidelines below), we will also automatically charge any remaining balances to close the account. I understand that if I do not give 24-hours notice when canceling an appointment, I will be charged a $100 cancellation fee for a therapy appointment and a $200 cancellation fee for a testing appointment. Phone consultations 15 minutes or longer may also be billed to my account and insurance. Please note, in an effort to be environmentally responsible, PCPA sends monthly emailed statements only. These statements will come from the following email address: noreply@psyquel.com. It is your responsibility to verify that these emails do not go to your spam folder.

Name of Person Responsible for Payment: _____

Responsible Party's Date of Birth: _____

Responsible Party's Address: _____

Name of Cardholder_____

Credit/Debit Card #_____ (MC, Visa, Amex, Disc)

Expiration Date_____

Security Code_____

I hereby accept responsibility for the charges incurred for this patient's treatment or assessment, regardless of any other arrangements with third parties, including insurers. In the unlikely event that a patient fails to remit payment or the credit card is denied, we will be forced to send the account to collections and/or pursue legal action. Patients will be held responsible for all associated fees, including, but not limited to, the cost of collection services, attorneys, administrative support, and therapist's time. If my credit card expires or changes, I am responsible for letting my child's clinician know about this change prior to his or her next appointment. I also understand that if my account balance gets to $300 or more, I will be required to pay the balance or initiate a payment plan before additional appointments can be scheduled.

_____ _____

Responsible Party Signature Date

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Permission for Release/Request of Confidential Information

To: _____
Name of primary care practice

_____
Street address, City, State, Zip

Re: _____ _____
Patient name Date of birth

I, _____(name of patient/guardian), hereby authorize Primary Care Psychology Associates and _____(name of primary care practice) to exchange information and for notes to be documented in the patient's medical record when applicable.

The type of information to be disclosed:

☐Evaluations ☐Medical Records ☐Diagnosis ☐Treatment Plan

☐Psychological/Medical Test Results ☐ Mental Health Record Summary ☐ Course of Treatment

☐Psychotherapy Notes ☐Other _____

Exceptions:_____

The purpose of such disclosure: Coordination of Care

Dates of records requested: First appointment to present

This consent is in effect for one year from the date signed below. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I hereby release all parties stated within this form from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization with certain exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. I also understand that a fee may be associated with the release of my records, and that my records may not be released until I, or the responsible party, pay the fee. Furthermore, I recognize that my records may not be released if I have an outstanding balance with Primary Care Psychology Associates and until the balance is paid. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____
Parent/Guardian signature Date

_____ _____
Patient 12-17 years old signature Date

_____ _____
Clinician/Witness Signature Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

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Treatment Guidelines

Emergency Contact: Clinicians are not available on an emergency or "on-call" basis. Patients may leave a message, but there may be an extended period of time before the clinician receives it and/or responds. Patients requiring immediate assistance must call 911 or go to the nearest emergency room. If patients require additional support, the clinician will provide a referral to an outside agency that can provide emergency staff.

Limits of Treatment: There are rare circumstances in which a clinician may be obligated to make a unilateral decision to terminate therapy. Such circumstances include, but are not limited to: the current treatment appears to be ineffective; threats are made against the clinician or his/her family; the clinician does not believe he/she has the necessary training to address a specific problem; or there is a significant therapeutic impasse. In such cases, the clinician will attempt to find a suitable referral. The clinician cannot be responsible as to whether this referral is accepted.

Closed Charts: If the patient has not returned calls/emails about scheduling and has not attended a session in 5 weeks, the patient chart will be considered closed. The chart can be re-opened again in the future if the clinician and patient mutually agree this is in the best interest of the patient.

Agreement for Co-Therapy: All professional treatment given is under the general supervision of Dr. Paul Kredow, Chief Psychologist and CEO of Primary Care Psychology Associates. Your insurance plan may also recognize Dr. Kredow, or other licensed professional, as a network provider and his or her name may appear on your explanation of benefits that you will receive from your insurance company. Primary Care Psychology Associates is also licensed in Illinois as a Group Practice with a practice NPI (National Provider Identifier). Dr. Kredow provides ongoing program supervision as well as clinical supervision or collaboration to all clinicians at PCPA. PCPA is also a training program for advanced graduate students (already possessing an MA or equivalent) and postdoctoral fellows in clinical psychology. All trainees are supervised by licensed psychologists, under the general supervision of Dr. Kredow. If you are being offered treatment by one of our trainees, you will be asked to complete a separate consent form describing our training program and supervision in more detail.

Insurance: Some insurance companies require the release of clinical information to obtain justification for coverage of services. If the insurance company makes such a request, we will provide this information on your behalf to support coverage of services through your insurance company.

Email Communication: Email communication should be limited to issues related to scheduling and billing. If you have clinical concerns or questions, they are best addressed during your session, or in some cases over the phone. Email is not an appropriate way of communicating urgent or emergency information. Your therapist will use reasonable means to protect the security and confidentiality of email information sent and received. However, because email is not a totally secure medium, your therapist cannot guarantee the security of email communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misuse.

_____ _____

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Child/Adolescent Information Form

Child/Adolescent's name:_____

Reason for Referral:

Briefly state the main concerns for which you are presently seeking help for your child.

_____
_____
_____
_____
_____

How long have you had these concerns about your child?

_____
_____

What things have you tried to correct these concerns?

_____
_____

What did you tell your child about coming here today?

_____
_____

Family Information:

Names of child's legal guardians: _____

Relationship to child: _____

Highest grade completed by: 1st parent listed: _____ 2nd parent listed: _____

Occupation: 1st parent listed: _____ 2nd parent listed:_____
Parents' marital status: ☐Married ☐Divorced ☐Separated ☐Deceased ☐Never Married

If the child's parents are married, how long have the parents been married? _____

If separated or divorced, age of child at the time: _____ Dates of any remarriages: _____

Frequency of visitation with non-custodial parent: _____

Language(s) spoken at home:_____

Please list all the members of your child's immediate family (include any half or stepsiblings):

Name	Age	Relationship to Child	Living within Household?
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐

Pregnancy and Development:

Was the pregnancy normal? ☐Yes ☐No

If No, please describe:_____

Length of pregnancy (months) _____ Number of weeks early _____ or late _____

Type of delivery: ☐Vaginal ☐Breech ☐Cesarean ☐Forceps aided

Complications during labor or delivery? ☐Yes ☐No
If Yes, please describe:_____

Birth weight: _____lbs. _____oz. Number of days in the hospital: _____

Apgar scores, if known: _____/_____ Did baby require help to breathe?☐Yes ☐No

Exposure to substances in utero? ☐Yes ☐No
If Yes, please describe:_____

Newborn difficulties: ☐None ☐Cyanosis (turned blue) ☐Stay in NICU or special care nursery
Other:_____

Indicate age at which your child achieved the following developmental milestones:

Sat without support	_____	Spoke first words	_____
Crawled	_____	Put 2-3 words together	_____
Walked	_____	Said sentences	_____
Toilet trained	_____	☐ Cannot recall specific ages, but all typical	

Concerns regarding your child's early development: ☐Yes ☐No

If Yes, please describe:_____

Concerns about feeding as infant: ☐Yes ☐No
If Yes, please describe:_____

Does your child have any problems with toileting? ☐Yes ☐No _____
If Yes, please describe:_____
_____

Does your child have any problems with going to sleep/staying asleep? ☐Yes ☐No
If Yes, please describe:_____
_____

Child's handedness: ☐Right ☐Left ☐Both (Ambidextrous)

Family history of left-handedness or mixed-handedness? ☐Yes ☐No

Medical History:

	Check if Yes	Ages	Describe
Allergies	☐		
Appetite/eating problems	☐		
Asthma	☐		
Clumsiness/poor motor skills	☐		
Chronic constipation	☐		
Chronic ear infections	☐		
Headaches	☐		
Hearing/ear problems	☐		
Head injury	☐		
Nightmares	☐		
Persistent high fevers	☐		
Physical disabilities	☐		
Seizures	☐		
Sensory Issues	☐		
Sleep apnea/snoring	☐		
Surgeries	☐		
Tics/twitching	☐		
Vision/eye problems	☐		
Alcohol use/abuse	☐		
Illicit drug use/abuse	☐		
Risky behaviors	☐		

Other current or past issues or concerns regarding your child's health: (specify age and any complications)_____
_____
_____
_____
_____

Hospitalizations: ☐Yes ☐No
If Yes, please describe:_____
_____

Current Medications: ☐Yes ☐No (if yes, please list)

Name of Medication	Dosage	Name of Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Difficulties following doctor's advice for medicine or other treatment: ☐Yes ☐No
If Yes, please describe:_____
_____

Please list counselors, psychotherapists, psychologists and psychiatrists who have seen your child:

Age	Provider Name	Service(testing, treatment, medication)	Helpful
____	_____	_____	☐Yes ☐No
____	_____	_____	☐Yes ☐No

Psychiatric hospitalizations: ☐Yes ☐No
If Yes, please describe:_____
_____

History of medications for mood or behavior: ☐Yes ☐No
If Yes, please describe:_____
_____

Previous mental health diagnosis: ☐Yes ☐No
If Yes, please describe:_____
_____

Family history of attention or learning difficulties: ☐Yes ☐No
If Yes, please describe:_____
_____
_

Family history of behavioral, emotional or psychological problems, including frequent use of alcohol or other substances to cope with stress: ☐Yes ☐No
If Yes, please describe:_____
_____
_____

School History:

Name of current school: _____
Grade: _____ Teacher: _____ Present letter grades: _____

Skipped grades: ☐Yes ☐No Which ones? _____ Reason:_____
Repeated grades: ☐Yes ☐No Which ones? _____ Reason: _____

Has a psychologist ever tested your child? ☐Yes ☐No
If Yes, please describe:_____
_____
If yes, please bring a copy of the report to our office.

Has your child ever received detention, been suspended or expelled? ☐Yes ☐No
If Yes, please describe:_____
_____
_____

Does your child receive any special education, enrichment or resource services? ☐Yes ☐No
If Yes, please describe:_____

	Check if Yes	Ages	Describe
Early Education Intervention	☐		
Occupational Therapy	☐		
Physical Therapy	☐		
Speech Therapy	☐		

If your child receives any special education services, please bring a copy of your child's current Individual Education Plan (IEP) or have it sent by the school.

Teachers report problems in: ☐Reading ☐Attention/concentration ☐Spelling ☐Behavior ☐Math ☐Social skills ☐Writing ☐Emotional adjustment

Previous schools attended Dates attended (begin - end)

_____ _____

_____ _____

Briefly describe any problems occurring during your child's attendance at these previous schools:

_____

_____

Describe any problems your child may have with peers (e.g., bullied, teased, no friends, poor social skills, aggressive, bossy, shy): _____

_____

_____

Is your child involved in any clubs, sports, or other organized activities: ☐Yes ☐No
If Yes, please describe:_____
Please list some of your child's personal strengths and talents: _____

_____

_____

Is there anyone not listed on this form who is an important person in your child's life (e.g., grandparent with whom your child spends significant time)? _____

_____

Please check any of the following stressful events that apply to your child or family and describe:

☐ Relocations: _____
☐ Job change: _____
☐ Deaths: _____
☐ Illnesses: _____
☐ Marital problems: _____
☐ Job changes: _____
☐ Someone significant moving out of the area: _____
☐ Experiencing a traumatic event: _____
☐ Witnessing a traumatic event: _____
☐ Physical or sexual abuse or neglect: _____
☐ Division of Child and Family Services (DCFS) involvement: _____
☐ Legal issues: _____
☐ Other: _____

Please write any additional remarks you may wish to make regarding your child. Thank you for taking the time to complete this information form.

Rev 10/18

Pediatric Symptom Checklist

Please mark under the heading that best describes your child:	Never	Sometimes	Often
1. Complains of aches and pains	☐	☐	☐
2. Spends more time alone	☐	☐	☐
3. Tires easily, has little energy	☐	☐	☐
4. Fidgety, unable to sit still	☐	☐	☐
5. Has trouble with teacher	☐	☐	☐
6. Less interested in school	☐	☐	☐
7. Acts as if driven by a motor	☐	☐	☐
8. Daydreams too much	☐	☐	☐
9. Distracted easily	☐	☐	☐
10. Is afraid of new situations	☐	☐	☐
11. Feels sad, unhappy	☐	☐	☐
12. Is irritable, angry	☐	☐	☐
13. Feels hopeless	☐	☐	☐
14. Has trouble concentrating	☐	☐	☐
15. Less interested in friends	☐	☐	☐
16. Fights with other children	☐	☐	☐
17. Absent from school	☐	☐	☐
18. School grades dropping	☐	☐	☐
19. Is down on him or herself	☐	☐	☐
20. Visits the doctor with doctor finding nothing wrong	☐	☐	☐
21. Has trouble sleeping	☐	☐	☐
22. Worries a lot	☐	☐	☐
23. Wants to be with you more than before	☐	☐	☐
24. Feels he or she is bad	☐	☐	☐
25. Takes unnecessary risks	☐	☐	☐
26. Gets hurt frequently	☐	☐	☐
27. Seems to be having less fun	☐	☐	☐
28. Acts younger than children his or her age	☐	☐	☐
29. Does not listen to rules	☐	☐	☐
30. Does not show feelings	☐	☐	☐
31. Does not understand other people's feelings	☐	☐	☐
32. Teases others	☐	☐	☐
33. Blames others for his or her troubles	☐	☐	☐
34. Takes things that do not belong to him or her	☐	☐	☐
35. Refuses to share	☐	☐	☐

Total Score _____ (For office coding)

Overall, do you think that your child/adolescent has difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people? (Please circle one)

☐No ☐Yes-Minor Difficulties ☐Yes-Definite Difficulties ☐Yes-Severe Difficulties

Do these difficulties upset or distress your child/adolescent? (Please circle one)

☐Not at all ☐Only a little ☐Quite a lot ☐A great deal

Do the difficulties interfere with your child/adolescent's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
Home Life	☐	☐	☐	☐
Friendships	☐	☐	☐	☐
Classroom Learning	☐	☐	☐	☐
Leisure Activities	☐	☐	☐	☐