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. 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 intake@pcpachicago.com. These forms can be completed and signed electronically by opening them with a PDF reader typing within them. If you have any questions, please contact our administrative assistant at 847-686-0090.

Patient Information:

Child's Full Name (as it appears on the insurance card): _____
Preferred Name:_____Date of birth:_____ Age:_____ Grade:_____
Race/Ethnicity:_____Primary Care Physician (PCP):_____
Referred by (if different than 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/or 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 Account Statements by E-Mail:

Email Address:_____

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

Late Cancellation/No Show Fees Notice: I understand that if I do not give 24-hours notice when canceling an appointment, or if my child no shows for their appointment, I will be charged a $100 late cancellation fee for a therapy appointment and a $200 late cancellation fee for a testing appointment. These fees will be charged to the credit card on file.

_____ _____
Parent/Guardian Signature Date

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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 therapist 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.

Firearm Concealed Carry Act: Firearms are not allowed on PCPA premises. PCPA clinicians are mandated mental health reporters. If a patient with a Firearm Owner Identification is deemed to be a clear and present danger, developmentally disabled, or intellectually disabled, we are mandated by law to report this to the Firearm Owner Identification (FOID) Mental Health Reporting System.

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 in the future if the clinician and patient mutually agree this is in the best interest of the patient.

Agreement for Co-Therapy: Primary Care Psychology Associates, LLC is licensed in the state of Illinois as a Group Practice with a practice NPI (National Provider Identifier). All professional treatment given is under the general supervision of Dr. Paul Kredow, Chief Psychologist and President of PCPA. 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. 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. 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.

Intoxicated Patients: Patients who present to the clinic intoxicated will not be offered services. A late cancellation fee of $100 will be charged to the account of any patient who is deemed by their therapist to be under the influence of alcohol and/or other substances at the time of their appointment.

_____ _____

Parent/Guardian Signature Date

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Payment and Financial Agreement

PCPA requires that all patients keep a valid credit or debit card on file. All copays, current account balances and fee-for-services will automatically be charged to the card on file at each appointment. For testing services, your credit card or debit card will automatically be charged at each appointment for any fee-for-service, deductibles, or out of pocket expenses according to your insurance plan benefits. In an effort to be environmentally responsible, all monthly statement will be sent through email only. These statements will be coming from the following email address: reply@psyquel.com. It is your responsibility to verify these emails do not go to your spam folder.

Credit Card Information

Name of Person Responsible for Payment:_____
Date of Birth of Responsible Person:_____ Relationship to Patient:_____
Responsible Person Address: _____
Name on Credit Card (if other than that of Responsible Person):_____
Credit Card #: _____ Exp. Date: _____ Security Code: _____

_____ (Initial) I understand and agree that I am financially responsible for all charges for any services rendered, including late cancellation fees.

_____ (Initial) I understand and agree that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balances.

_____ (Initial) I understand and agree that it is my responsibility to know if my insurance has a deductible, co-payment, co-insurance, out-of-pocket, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to be financially responsible for all.

_____ (Initial) I understand and agree that if my insurance requires a referral from my primary care physician, it is my responsibility to obtain the referral. Without a referral, my insurance will not pay for any services and I will be responsible for payment.

_____ (Initial) I understand and agree that it is my responsibility to inform PCPA in case of any changes to my insurance coverage prior to my next appointment. Claims denied due to submission to an expired insurance plan may be denied and may become my responsibility.

_____ (Initial) I understand and agree that any phone/video consultations 15 minutes or longer may be billed to my insurance and I would be responsible for any patient fees according to my plan.

_____ (Initial) If the credit card on file changes/expires, I am responsible for informing my clinician.

_____(Initial) I understand and agree, if my account is considered closed (see treatment guidelines), the remaining balance will be charged to the credit card on file to close the account.

_____(Initial) I understand and agree that a $25 fee for any returned checks will be charged to my account.

_____(Initial) I understand and agree that if my account balance is over $300, I will be required to pay the balance in full or initiate a payment plan before additional appointments at PCPA can be scheduled.

_____(Initial) I understand that unpaid balances that are more than 120 days late may be turned over to a collection agency. If my account is turned over to a collection agency, I will be responsible for an additional 33.33% of the unpaid balance to account for collection services expenses. I further agree to pay reasonable administrative fees, attorney fees, and cover costs arising out of any litigation concerning the collection of this account or any other fees deemed necessary.

By signing this form, I acknowledge that I understand and agree to the payment and financial agreement I am making with Primary Care Psychology Associates, LLC. I accept responsibility for the charges incurred for treatment or assessment, regardless of any other arrangements with third parties, including insurers.

_____ _____
Patient/Guardian Signature Date

_____ _____
Signature of Person Responsible for Payment (if different from patient) Date

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Permission for Release/Request of Confidential Information

_____
Name of primary care practice

_____
Street address, City, State, Zip Phone Fax

Re: _____ _____
Patient name Date of birth

I, _____(**name of patient/guardian**), hereby authorize Primary Care Psychology Associates, LLC and _____(**name of <u>your</u> Primary Care Practice or Physician**) to exchange information and for notes to be documented in the patient medical record when applicable.

The type of information to be disclosed:
□All relevant information □Medical Records only □Psychotherapy Notes only
□Psychological/Medical Test Results □Mental Health Record Summary
□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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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?_____
_____
_____

Family Information:

Names of child's legal guardians: _____
Relationship to child:_____
Occupation of 1st parent listed:_____
Occupation of 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?
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐
_____	____	_____	☐

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Pregnancy and Development:

Was the pregnancy normal? ☐Yes ☐No

If No, please describe:_____

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

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

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

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

Newborn difficulties**:**_____

Concerns regarding your child's early development: _____

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

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

Name of Medication	Dosage	Name of Prescribing Physician

Past Psychiatric Medications: _____

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

Age	Provider Name	Service(testing, treatment, medication)	Helpful
			☐Yes ☐No
			☐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	☐	_____	_____
Toileting Issues	☐	_____	_____
Vision/eye problems	☐	_____	_____
Alcohol use/abuse	☐	_____	_____
Illicit drug use/abuse Risky behaviors	☐	_____	_____
	☐	_____	_____
Other: _____	☐	_____	_____

Current weight:_____lbs. _____oz. Current Height: _____ft. _____in.

Family history of attention or learning difficulties, 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:

Subject	Grade
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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

_____

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 received any of the following:	Check if Yes	Ages	Describe
Early Education Intervention	☐	_____	_____
Occupational Therapy	☐	_____	_____
Physical Therapy	☐	_____	_____
Speech Therapy	☐	_____	_____
Individual Education Plan (IEP)*	☐	_____	_____
504 Plan*	☐	_____	_____

If your child receives any special education services, please bring a copy of your child's current IEP or 504 Plan to your first appointment.

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: _____

_____

_____

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

☐ Relocations: _____
☐ Job change: _____
☐ Deaths: _____
☐ Illnesses: _____
☐ Marital problems: _____
☐ Someone significant moving out of the area: _____
☐ Experiencing/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._____

_____

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 _____

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 mark one)

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

Do these difficulties upset or distress your child/adolescent? (Please mark 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	☐	☐	☐	☐