CEDAR CENTRE PSYCHIATRIC GROUP L.L.P.

PLEASE PRINT LEGIBLY!! PLEASE FILL OUT, SIGN AND DATE BOTH SIDES OF THE FORM!

Patient's Full Name_____

Address_____

City, State & Zip_____

Home Phone_____ Social Security #_____

Date of Birth_____ Male ☐ Female ☐ Student full time ☐ part time ☐

Guarantor's Full Name_____

Address_____

City, State & Zip_____

Home Phone_____ Social Security #_____

Date of Birth_____ Male ☐ Female ☐ Work Phone_____

Employer_____ Marital Status_____

Emergency Contact:

Name_____Phone_____Relationship_____

INSURANCE INFORMATION

Insurance Company Name_____

Claims Address_____

City, State & Zip_____

Insurance Phone # _____Precertification Required? Yes ☐ No ☐

Name of Subscriber on Card_____

Date of Birth_____Employer_____

Policy #_____Group #_____

Secondary Insurance Company Name_____

Claims Address_____

City, State & Zip_____

Insurance Phone #_____Precertification Required? Yes ☐ No ☐

Name of Subscriber on Card_____

Date of Birth_____Employer_____

Policy #_____Group #_____

I authorize payment of medical benefits to Cedar Centre Psychiatric Group. I understand Cedar Centre will file my insurance as a courtesy to me, but I am financially responsible and agree to pay Cedar Centre within 60 days, even if my insurance has not yet paid.

Name_____ **Date**_____

NOTICE TO ENROLLEES OF ANY HMO PLAN:

If your benefit plan requires you to contact your Mental Health Plan, prior to receiving services at our office and you have not done so, you will be responsible for payment in full of services received.

Please initial here: _____

CONSENT TO RELEASE MENTAL HEALTH INFORMATION

I, the undersigned, hereby authorize Cedar Centre Psychiatric Group to disclose to:

Name of Insurance Company	**Address**

The following information:
A) Administrative Data (i.e., name, address, age)
B) Diagnosis
C) Voluntary or involuntary treatment status
D) Estimated time during which treatment might continue
E) Treatment information including prescriptions & current status

I understand that the information is to be used for billing purposes; I further understand that this will be a lifetime agreement, which I may revoke at any time buy sending written notice to Cedar Centre Psychiatric Group.

I understand that any release, which has been made prior to my revocation and which was made in reliance upon this authorization, shall not constitute a breach of my rights to confidentiality. I understand that I may request to review the disclosed information by contacting Cedar Centre Psychiatric Group.

A photocopy of this consent shall be deemed the same as the original.

Name	**Date**

CEDAR CENTRE
PSYCHIATRIC GROUP, L.L.P.
P.O. Box 1408
Cedar Rapids, IA 52406-1408 (319)-365-3993

Patient Name_____ Account #_____

1) ----AUTHORIZATION FOR TREATMENT

I have chosen to receive treatment through Cedar Centre Psychiatric Group for myself or my minor child. I understand I may terminate at any time. I understand that treatment is a cooperative effort between myself and my doctor and/or counselor. I understand that I have a right to be fully informed regarding the benefits or potential problems associated with any treatment I may receive. I understand that information collected about me shall be confidential unless a Release of Information is given. Any Release of Information is valid only for the time period indicated and may be rescinded at any time. Exceptions will apply only in circumstances that legally require sharing information.

2) ----AUTHORIZATION FOR REMINDER CALLS

I authorize my health care provider to use an automated telephone system. The name of my scheduled treating provider; and the time and place of my scheduled appointment will be disclosed for the limited purpose of contacting me to notify me of a pending appointment. I also authorize my healthcare provider to disclose limited protected health information regarding pending appointments to third parties that may answer my telephone, and leave a reminder message on my voice mail system or answering machine.

3) ----ACKNOWLEDGMENT OF OFFICE POLICY

I hereby acknowledge that I was given the opportunity to receive and read a copy of the Cedar Centre Psychiatric Group's Office Policy.

4) ----ACKNOWLEDGMENT OF PRIVACY POLICY

I hereby acknowledge that I was advised a copy of the Cedar Centre Psychiatric Group's Notice of Privacy Practices is posted on their website. I also understand I can request a paper copy at any time.

Acknowledgment and agreement of above numbers #1, #2, #3 & #4

_____ _____
Signature Date

_____ _____
Relationship Witness

Cedar Centre Psychiatric Group Child/Adolescent Intake Form

This information is important in evaluation and treatment of your child.
Please fill out the following questionnaire as completely as possible.

Child's Name:_____ Date:_____

Date of Birth: _____ Age:_____ Sex: Male Female

Your Name:_____ Relationship to Patient _____

Who referred you to this clinic? _____

Please list the reasons that bring you here today. They may include certain problems, issues, significant losses or changes that are causing you stress.

1. _____
2. _____
3. _____

Please list the goal(s) you hope to achieve in treatment? What do you hope treatment will help your child to change?

1. _____
2. _____

Has your child seen a therapist or counselor before? Yes No Or a psychiatrist? Yes No

If yes: Therapist/Counselor/Psychiatrist Dates (from/to) Problem/Area of Concern

_____

_____

Please check all that apply to your child:

__ withdrawn
__ increased aggression
__ crying spells
__ anger outbursts
__ physical abuse issues
__ change in friends
__ hyperactive
__ school difficulties
__ depression
__ irritable
__ bedwetting
__oppositional
__ sexual abuse
__ obsessions
__ thoughts of hurting self
__ thoughts of hurting others
__ decreased energy and motivation
__ nightmares
__ non-compliant
__ fire setting
__ perfectionist tendencies
__ feelings of hopelessness
__ other

Please list any recent major family changes, losses, separation, deaths, moves, etc.

_____

_____

Has your child ever been hospitalized for emotional problems? Yes No

Has your child ever been in a drug/alcohol treatment program? Yes No

Family/Relationship History:

Mother: _____ Age: _____ Occupation: _____

Father: _____ Age: _____ Occupation: _____

Family/Relationship History (continued)

Siblings: Name Sex Age Full/Half/Step

_____

_____

_____

_____

Who lives in the household with the child? _____

_____

_____

Is there currently a change in custody, visitations, or a pending divorce? Yes No

Do any members of the child's family suffer from major health problems at this time? _____

Have any blood relatives of the child experienced the following? (check all that apply)

__ suicide __ schizophrenia __ learning disabilities __ other addictive behaviors
__ depression __ legal problems __ attempted suicide __ other mental health issues
__ anxiety __ developmental delay __ drug/alcohol abuse __ intellectual impairment

Any history of abuse in your child's family? Emotional Verbal Physical Sexual

Has your child ever been abused? Emotional Verbal Physical Sexual

If yes, was this investigated? Yes No Are there any guns in your home? Yes No

Is your child or anyone in the child's family currently involved with the court or legal system? Yes No

Is your family currently involved with social services or the Department of Human Services (DHS)? Yes No

Medical History:

Primary Care Clinic: _____ Doctor: _____

Last Medical Exam: _____ Past hospitalizations, surgeries, medical issues: _____

_____

Current Medical Conditions: _____

Current Prescribed Medications: _____

Allergies: _____

Developmental History:

Birth Weight: _____ Born how many days early or late? _____

Did the child have to stay in the hospital after mother was discharged? Yes No How Long? _____

For what reason? _____

How many miscarriages has mother had? _____ Stillborn children? _____

Did mother have any of the following complications during pregnancy? (check all that apply)

__ flu __surgery __ x-rays __spotting/bleeding __ threatened miscarriage __ other:_____

What medications did mother take during pregnancy (other than vitamins)? _____

_____

Age child sat: _____walked: _____toilet trained: _____spoke first words: _____

Was the child separated from his/her biological parent(s) for a significant period of time? Yes No

How long was the separation? _____Reason: _____

Have you or another adult had any concerns about your child's development in any of the following areas?

	Evaluated by:
_____speech and language development	_____
_____hearing	_____
_____vision	_____
_____intelligence/ability to learn	_____
_____bladder/bowel control	_____
_____emotional/maturity level	_____
_____social skills	_____
_____eating habits	_____
fine motor skills (write, color, etc)	_____
gross motor skills (walk, run, etc)	_____

Does your child have any physical disabilities or limitations of movement, sight, or hearing? Yes No

If yes, please explain: _____

Education/Work:

Grade in School: _____School name: _____

Special placement (if any): _____

Leisure/Recreation:

What does your child enjoy doing in his/her spare time? _____

_____

How often does he/she engage in these activities? _____

Spirituality:

Spiritual/Religious Affiliation: _____

Finances:

How much is money and debt a problem in the life of this child's family?

Not at all		A little bit			Moderately			A lot		A Great Deal
0	1	2	3	4	5	6	7	8	9	10

Cedar Centre Psychiatric Group – Please provide medical information as best you can

Name: _____ **DOB:** _____ **Date:** _____
Allergies: _____
Medications (include herbs, supplements, vitamins, over the counter, eye drops, ALL medications please): _____

_____

_____

Past psychiatric medications:

_____

_____

Hospitalizations/Surgeries (include all medical/psychiatric, year and reason):

_____

_____

_____

Have you ever had the following:
Birth Injury(Blue baby): NO YES(explain): _____
Head injuries: NO YES(explain): _____
Loss of consciousness or concussions? NO YES(explain): _____
Seizures: NO YES(explain): _____
Meningitis or Encephalitis: NO YES(explain): _____
ECT(shock treatments): NO YES(explain): _____
Serious Accidents: NO YES(explain): _____
Do you smoke: NO YES **Do you drink alcohol: NO YES**
Do you have any problems with the following (if you do, please circle and describe below):
Constitution: Fever, Chills, Sleep problems, Appetite or weight changes
HEENT: Vision, glaucoma, hearing problems, smelling problems, taste or swallowing problems
Blood and Immune: weak immune system, allergies, HIV/Aids, bleeding disorder, lymph disorder, cancer
Neurologic: Headache, Tremor, Dizzy, Numbness, Multiple Sclerosis, Parkinson's, Dementia, Memory problems, Restless legs, Seizures, Stroke, Brain or spinal injury or infection, Pinched nerves
Hormones: Fatigue, Tired, Excessive sweating, Hot flashes, Libido changes, Thyroid, Diabetes, Menopause
Gastrointestinal: Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Blood in stools, Hepatitis
Cardiovascular: Chest pain, Palpitations, Heart attacks, Heart murmurs, Heart failure, fatigue with activity
Pulmonary: Asthma, COPD, Emphysema, Chronic cough, Wheezing, Coughing up blood
Rheumatology: Fibromyalgia, Chronic Fatigue, Arthritis, Lupus
Skin: Rashes, Easy bruising, Eczema, Psoriasis, Acne, breast problems
Musculoskeletal: Joint problems, Stiffness, Osteoporosis, Muscle or bone diseases, sciatica
Genitourinary: Kidney problems, Urine problems, blood in urine, prostate problems, genital infection
Other details or problems: _____

_____

Are you pregnant? NO YES Are you intending to become pregnant while in treatment? NO YES

_____ _____

Patient (or Guardian) Signature **Provider Signature**