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 INTAKE INFORMATION

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

CHILD'S FULL NAME: _____

DATE OF BIRTH: _____

WITH WHOM IS THE CHILD LIVING: _____

RELATION TO CHILD: _____

MOTHER'S FULL NAME: _____ AGE: _____

OCCUPATION: _____

LAST GRADE OF SCHOOL COMPLETED: _____

FATHER'S FULL NAME: _____ AGE: _____

OCCUPATION: _____

LAST GRADE OF SCHOOL COMPLETED: _____

SCHOOL CHILD IS PRESENTLY ATTENDING: _____ GRADE: _____

DOES YOUR CHILD HAVE A 504 PLAN, IEP, OR OTHER ACCOMMODATIONS? _____

CHILD EVER BEEN PSYCHOLOGICALLY TESTED? _____ IF YES, BY WHOM: _____

_____

HAVE YOU USED ANY OTHER SERVICES RELATED TO YOUR CHILD'S BEHAVIOR AND/OR FAMILY PROBLEMS? _____ IF SO, LIST:

_____

_____

PLEASE LIST ALL OTHER CHILDREN IN THE FAMILY. NOTE IF ANY HAVE A PROBLEM WITH HEALTH, LEARNING OR BEHAVIOR:

FULL NAME	**AGE**	**RELATION**	**(natural, step adopted, foster)**	**WHERE LIVING**	**PROBLEM**

HAS YOUR CHILD EVER BEEN HOSPITALIZED FOR ANY REASON (EXCEPT BIRTH)? _____ IF YES:

DATE WHERE REASON TREATMENT

HAS YOUR CHILD EVER HAD ANY SERIOUS ILLNESSES / ACCIDENTS?

DATE ILLNESS / ACCIDENT

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? IF YES,

NAME DOSAGE PRESCRIBED BY

DOES YOUR CHILD HAVE ANY ALLERGIES? _____

BIRTH INFORMATION

BIRTH WEIGHT: _____

BORN EARLY/LATE? _____ IF YES, BY HOW MUCH? _____

DID THE CHILD HAVE TO STAY IN THE HOSPITAL AFTER MOTHER WAS DISCHARGED? _____ HOW LONG? _____

FOR WHAT REASON? _____

HAS MOTHER HAD ANY MISCARRIAGES? _____ HOW MANY? _____

HAS MOTHER HAD ANY STILLBORN CHILDREN? _____

DID MOTHER HAVE ANY OF THE FOLLOWING COMPLICATIONS DURING PREGNANCY? (please check all that apply)

FLU_____ SURGERY_____ X-RAYS___ SPOTTING / BLEEDING_____

THREATENED MISCARRIAGE_____ OTHER_____

DID MOTHER TAKE ANY MEDICATIONS DURING PREGNANCY (other than vitamins)? _____ IF YES, WHAT _____

BIRTH INFORMATION continued

AGE CHILD FIRST SAT:_____ WALKED:_____

TOILET TRAINED:_____ SAID FIRST WORDS:_____

HAVE ANY BLOOD RELATIVES OF THE CHILD EXPERIENCED THE FOLLOWING? (check all that apply):

SUICIDE_____ ATTEMPTED SUICIDE_____ ANXIETY_____ DEPRESSION_____

SCHIZOPHRENIA_____ LEARNING DISABILITIES_____ LEGAL PROBLEMS_____

INTELLECTUAL IMPAIRMENT_____ DEVELOPMENTAL DELAY _____ ADHD ___

DRUG/ALCOHOL ABUSE_____ AUTISM _____

NAME OF PERSON / AGENCY WHO SUGGESTED REFERRAL: _____

_____

PLEASE SUMMARIZE YOUR CONCERNS BELOW (turn sheet if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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**