

Atlantic Psych Associates

1518 Savannah Road, Lewes, DE 19958
www.AtlanticPsychAssociates.com

Phone: 302-448-4266
Fax: 302-448-4193

Forensic Coordinator
Phone: 302-450-6441

HIPAA

() _____ Offered and accepted copy of HIPPA () _____ Offered but declined copy of HIPAA
Initials Initials

Date: _____

DEMOGRAPHICS

Patient's Last Name _____ First Name _____ Middle Initial _____

Nickname (goes by) _____ SSN _____ DOB _____

Address _____
Street City Zip Code

Phone Numbers: Home _____ Cell _____ Work _____

Email: _____

Referred by () PCP () Friend () Attorney () Ins. Co. () Phone book () Internet

If applicable, referrer's name: _____

Emergency Contact (name and number) _____

MEDICAL

PCP Name _____ Practice/Clinic Name _____

Address _____

PCP Phone _____ PCP Fax _____

Allergies _____

INSURANCE () Yes () None

Primary Insurance

ID# _____ Group # _____

Insurance Company _____

Patient's Relationship to Insured () Self () Spouse () Child () Other

Insured's Name (Last, First, MI) _____

Insured's Address _____

Street City Zip
Insured's Phone Number _____ Insured's Employer _____

Insured's Gender () Male () Female Insured's DOB _____

Secondary Insurance () Yes () None

ID# _____ Group # _____

Insurance Company _____

Patient's Relationship to Insured () Self () Spouse () Child () Other

Insured's Name (Last, First, MI) _____

Insured's Address _____

Street City Zip
Insured's Phone Number _____ Insured's Employer _____

Insured's Gender () Male () Female Insured's DOB _____



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Atlantic Psych Associates Appointment Reminder Preference

I, _____ would prefer to be notified of appointments for

_____ via:
Patient Name

Automated phone call to _____
Phone number

Text message from to _____
Phone number

My cell carrier is ACS AllTell AT&T Boost Cricket
Metro PCS Nexttel Qwest Sprint SunCom T-Mobile
Verizon Virgin VoiceStream U. S. Cellular Other _____

I understand that an appointment reminder is a courtesy, and that if the preference indicated above isn't working (for example, number no longer in service, etc.) the staff at Atlantic Psych Associates will not be able to leave an appointment reminder. All no-show fees will still be applicable.

Signature

Date

Print Name



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**Atlantic Psych Associates
Patient Information Disclosure Authorization
to/from Primary Care Physician**

I understand that my records are protected under the applicable law(s) governing health care information that relates to mental health services and under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____ hereby authorize _____
(Patient's Name) (Treating Clinician's Name)

PLEASE CHECK ALL THAT APPLY:

- To release any applicable information to my Primary Care Physician
- To obtain any applicable information from my Primary Care Physician

Signature of Patient or Legal Guardian

Date

Print the name signed above

Primary Care Physician: _____
Telephone: _____



Child/Adolescent History

Your child's full name: _____

Birth date: _____ School: _____ Grade: _____

Sole Custody? Y or N Name: _____

Joint Custody? Y or N Name(s) _____

Family (list yourself and all members living in the home including your child):

Name	Age	School/Employer

Immediate family living outside of the primary home:

Name	Age	School/Employer

Have there been any parental separations or divorces; give date(s), name(s) of other parent figures?

Does either of the birth parents live elsewhere?

Father: Yes No Where:

Mother: Yes No Where:

Please state what you hope to accomplish for you and/or your child by coming here today:

You may put Y for yes and N for no if it does not apply:

Do you think your child is contributing to a problem? _____ Do you think that others are making a problem for your child? _____

Do you think it is possible that your child has emotional or behavior problems? _____

Do you have concerns about any negative stigma or effects on reputation for you or your child because of your visit to a psychologist? _____

Psychiatric History:

Has your child ever received psychiatric or psychological treatment of any kind before? Y or N

Please list previous psychological treatment below:

Year Prescribed?	Problem	Psychiatrist, Therapist	How long?	Medication (dosage, frequency)
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Has your child ever deliberately hurt him/herself, overdosed, or attempted suicide? [] No [] Yes
If Yes, when, how often, and what did he/she do

Has your child ever threatened to harm him/herself or anyone else? [] No [] Yes
If Yes, who? _____

Have you ever known anyone who committed suicide? [] No [] Yes
If Yes, who? _____

Were there any concerns about delayed development?

If so, what?

If the child was in Day Care before the age of five years, were there complaints of fighting, biting, kicking, and destructiveness?

Do any adults smoke cigarettes in the home?

Is it possible that the child ate large amounts of lead-based paint?

Are you (one or both parents) experiencing a lot of stress in raising this child?

In your personal life?

In your career?

Have there been such times before in the child's lifetime?

Please describe:

School grades usually (circle ALL that apply): A's, B's, C's, D's, F's, S's, N's, E's, G's, P's, U's

If you wish to make a comment about the influence of religious factors in your child's life:

What follows is a checklist for children and adolescent behavioral and emotional problems. Please check those statements that apply to your child or teenager now or in the past and leave blank those that do not apply.

_____ Often fails to give close attention to details or makes careless mistakes in schoolwork, chores or other activities.

_____ Often has difficulty maintaining attention to school work, chores or play activity.

_____ Often does not seem to listen when spoken to directly.

_____ Often does not follow through on instructions and fails to finish schoolwork, chores or other activities, but is not being disobedient and is not having trouble understanding the instructions.

_____ Often has difficulty organizing schoolwork, chores and other activities.

_____ Often dislikes, avoids or is reluctant to start tasks that require continuous mental effort such as homework or schoolwork.

_____ Often loses things that are important in tasks or activities (books, assignments, pencils, tools, toys).

_____ Often is easily distracted by noises, things to look at.

_____ Often is forgetful in ordinary daily activities.

_____ Often fidgets with hands or feet or squirms a lot.

_____ Often leaves seat in the classroom or other places where remaining seated is expected.

- Often runs about, climbs excessively or notes and inner feeling of restlessness.
- Often has trouble playing or doing leisure activities quietly.
- Often on the go as if driven by a motor.
- Often talks excessively.
- Often blurts out answers before questions have been completed.
- Often has trouble awaiting turn or waiting in line.
- Often interrupts or intrudes on others, butts into conversations, grabs others to be noticed.

If you checked some of these behaviors, were some of them present before first or second grade?:

Some of the behaviors cause trouble in more than one area of a child's life, such as home, school, church or community: Y N.

- Often loses temper.
- Often argues with adults or authority figures.
- Often refuses adult requests, commands or rules.
- Often annoys others on purpose.
- Often blames others for his/her mistakes.
- Often is very touchy or annoyed by the slightest comments.
- Often wants to get back at others or get even with them.

If you have checked any of the behaviors in the list above, have they gone on at least 6 months?

- Often has been depressed and/or grouchy most of the day, most days for at least one hour (on/off).
- I have noticed poor appetite or overeating.
- I have noticed trouble sleeping or sleeping too much.
- I have noticed low energy and fatigue.
- I believe there is low self-esteem about certain things.
- I believe that my child has displayed these symptoms for more than 2 months at a time during the year.

- Often bullies, threatens or intimidates others.
- Often starts physical fights (does not apply to occasional fights between siblings).
- Has been physically cruel to people, including siblings.
- Has been physically cruel to animals.
- Has stolen from someone while actually facing him or her.
- Has forced someone into sexual activity.
- Has engaged in fire setting with the intention of causing serious damage to property or harm to people.
- Has deliberately destroyed others' property.
- Has broken into someone else's house, building or car.
- Before age 13, has often stayed out late at night despite parental warnings.

_____ Has run away from home overnight more than once or stayed away on one occasion for days.

_____ Has often been truant from school before age 13.

_____ My child smokes cigarettes.

_____ My child uses alcohol.

_____ My child inhales or huffs paint, glue or gasoline.

_____ My child chews tobacco.

_____ My child uses illegal substances or abuses prescribed medications.

_____ My child gets upset (or used to) if I left the house for a short time or if I said I would be leaving.

_____ My child worries (or used to) about getting kidnapped.

_____ My child refuses to go to school or elsewhere without me.

_____ My child refuses to be alone in the house without me.

_____ My child refuses to go to sleep unless I am close by.

_____ My child tells (or used to) me about nightmares where we got taken away from each other.

_____ My child has (or used to have) bad headaches and/or stomachaches, with going to school, bed or if I was going to be away from the house.

If you have checked any of the behaviors listed above, did they occur for at least four weeks in your child's life? Did they occur before/after first grade ?

_____ My child worries nowadays about sports, school, friends and/or appearance excessively.

_____ My child seems to have trouble controlling these worries.

When bothered by these worries, my child is:

_____ Restless

_____ Easily fatigued

_____ Unable to concentrate

_____ Irritable

_____ Bound up or in pain from tight muscles

_____ Unable to fall asleep, stay asleep or sleep well

_____ My child will not touch things, eat things or go near things for fear of getting dirty, acquiring germs or getting sick.

_____ My child has habits that seem excessive or unusual (e.g., excessive cleaning, praying, counting, checking, etc.)

Finally, all of the various symptoms I have checked cause interference in my child's life. (circle one) Mild Moderate Severe

The space below is provided for additional comments or information you think the doctor needs to know:

Form completed by (must be filled in) :

Date:



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Patient Rights & Responsibilities.

Part 1. The Rights of Patients

1. You have the right to be treated with respect and dignity and receive quality services.
2. You have the right to have your clinical information kept confidential within the constraints of the law.
3. You have the right to an explanation of your condition and treatment.
4. You have the right to participate in decisions involving your treatment. If you decide to refuse treatment or do not follow your treatment plan, you have the right to be told what the possible results could be.
5. You have the right to have your complaints heard.
6. You have the right to request a male or female therapist and a therapist who understands and speaks your language. We will make reasonable efforts to accommodate such requests.
7. You have the right to request a change of therapist. This right has limits. You may ask for and possibly receive a second therapist.
8. You have the right to receive assistance with respect to knowing and understanding your mental health/ substance abuse benefits.

Part 2: The Responsibilities of Patients

1. You are expected to support the patient therapist relationship. For example, you should exercise courtesy and make every effort to keep scheduled appointments. A "No Show" payment may be applied if you miss an appointment without notifying the office. A "Late Cancellation" fee may be applied if you cancel an appointment with less than 24 hours notice in advance of your scheduled appointment.
2. You are expected to present true and accurate information when requested and participate actively in the planning of your treatment.
3. You are expected to follow the recommendations of the clinical treatment program and to address any problems or complaints about your treatment to your Therapist or the Network Manager.
4. You may not threaten or endanger the life, health, or social well-being of staff members or patients Atlantic Psych Associates, LLC.
5. You may not engage in illegal acts, such as forging or falsifying staff member's name on any forms requiring a signature.
6. You are expected to pay any necessary fees at the time of your appointment.
7. You are expected to notify your therapist if you decide to stop treatment.
8. You are expected to respect the confidentiality of other patients.

Complaints/Feedback

Feedback, either positive or negative, regarding any services provided by Atlantic Psych Associates, LLC is appreciated. You have the right to file a complaint about any and all services provided and to receive feedback in a reasonable amount of time. We encourage you to discuss any complaints with your Therapist. You may however, contact the Office Manager, Christina Tetrault, to file a complaint or give feedback regarding the services provided at Atlantic Psych Associates, LLC.

I have read the statements above and understand my rights, my responsibilities, and the process to lodge complaints, and agree to comply with these statements.

If any of these rights and responsibilities are unclear, you have the right to have them explained to you. Upon request, these rights and responsibilities must be read to you and explained. Atlantic Psych Associates, LLC does not discriminate on the basis of age, race, creed, sex, ethnicity, color, national origin, marital status, sexual orientation, handicap or religion

Patient Signature

Date

Witness

Date



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Patient Contract

CONFIDENTIALITY STATEMENT:

I understand that all information between myself and my therapist is held strictly confidential, and my therapist will not release any information about my therapy unless permitted by law or:

1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/elder abuse/neglect is suspected.

I understand that in the latter three cases, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

RELEASE OF INFORMATION:

In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other Atlantic Psych Associates, LLC providers and facilities for purposes of diagnosis and treatment. I further authorize the release of information for claims, certification/case management/quality improvement and other purposes related to the benefits of my Health Plan. (Releases of information to providers, family, etc., require a separate form.)

FINANCIAL TERMS:

Payment is to be made in full with cash, personal check, or credit card at the time of the session. For those plans which Atlantic Psych Associates accepts assignment upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my Provider will be paid directly by the carrier. I will be responsible for any applicable deductibles and co-payments. I agree to make these payments at each appointment. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered.

CONSENT FOR TREATMENT:

I further authorize and request that my therapist carry out psychological or psychiatric examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

CANCELED/MISSED APPOINTMENTS:

I understand that if an appointment is missed or canceled with less than 24 hours' notice, I will be billed a no show / cancelation fee that is to be paid prior to my next session. I also understand that repeated no shows or canceled appointments (two or more) could result in termination of my mental health services at Atlantic Psych Associates.

TELEPHONE CONSULTATIONS:

I understand that routine calls for the purpose of scheduling and billing are an expected part of the services at Atlantic Psych Associates and are not billed. Telephone calls that are primarily therapeutic in nature and extend more than five minutes, or are frequent, will be prorated and billed at the usual rate.

TERMINATION OF TREATMENT

I understand that once mental health treatment begins, I have the right to withdraw my consent to participate in mental health treatment at any time that seems appropriate. I will make every effort to discuss my concerns about progress of my treatment with my Therapist/Clinician prior to terminating therapy in this way. I understand that treatment will also be considered terminated and my file will be considered inactive once a period of 90 days has passed without contact from me, unless otherwise arranged between my therapist and myself. I understand that treatment may begin again at any time, based upon the availability and discretion of my therapist. I understand that if therapy cannot be reinstated, I will be provided the names and numbers of other qualified treatment providers.

I _____ have read the materials presented in this disclosure statement. My signature indicates that I understand the information presented in this packet and all my questions have been answered to my satisfaction. I agree with the conditions of therapy that are either stated or implied and commit myself to compliance with them.

I also agree that my Therapist/Clinician may discuss information regarding my case with those professionals covering for him/her in their absence. I understand that I have the right not to sign this form and choose to discuss my concerns with my Therapist/Clinician before formal mental health treatment begins.

Signature of Client/Guardian Date Signature of Staff/Clinician Date

I have discussed client questions concerning this contract/disclosure statement:
Initials: Date:

Atlantic Psych Associates, LLC



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FINANCIAL AGREEMENT

Page 1

Thank you for trusting Atlantic Psych Associates to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Patient Signature

Printed Name

Date

Parent/Guardian Signature

Printed Name

Date

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare (if applicable)

We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Patient Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by our insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Patient due balances noted on your monthly statement are due within 30 days of receipt. Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

Deposits/Retainers (if applicable)

Patients coming to Atlantic Psych Associates under forensic circumstances – i.e., by court order, agreed stipulation or on recommendation of their attorney -- will be required to pay a retainer. Atlantic Psych Associates does not accept insurance for forensic matters.

Payment Options

Atlantic Psych Associates accepts cash, check, VISA, MasterCard and Discover (however, no American Express). We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our Practice Manager at 302-448-4266 to make payment arrangements. Accounts with a patient due balance outstanding over 90 days will be charged finance charges of 20%.

No Show Fees

Appointment reminders are done as a courtesy. Patients will be held responsible for missed appointments whether or not a reminder is delivered. For example, if a phone isn't answered, is repeatedly busy, voice mail/message machine is full, email goes to spam and/or text message is deleted or not read, no reminder can be delivered. A 24 hour notice is requested if you cannot make/keep an appointment and a no show fee of \$50.00 will be assessed.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our collection analyst to discuss payment arrangements. Referral to a collection agency, or naming Atlantic Psych Associates, LLC in a bankruptcy filing, you will be charged a processing fee and any applicable legal fees. NSF checks will result in a \$25 processing fee.

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I would like to keep a credit card on file. I understand that this card will be charged for the cost of my appointment (or my co-pay, if using insurance) at the time of service. No charge will be made toward outstanding balances without my additional consent.

Printed Name

Signature

Date

Receipt:

I would like a receipt e-mailed to (address):

_____ I do not request a receipt