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 (Initials, Date)________

Offered but declined copy of HIPAA (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 ______________ Ext _____

Email: ____

Patient Referred by: PCP Friend Attorney Ins. Co. Found on internet

If applicable, referrer's name:
____

Emergency Contact (name and number)____

MEDICAL

PCP Name ________________________Practice/Clinic Name_________________________________

Address ____

PCP Phone____________________________ PCP Fax ___________________________________

Allergies ____

Do you see a psychiatrist or similar practictioner? Yes No

Psychiatrist Name ________________________Practice/Clinic Name__________________________

Address ____

Psychiatrist Phone____________________________ Fax ______________________________

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 _____________________________

Atlantic Psych Associates

Appointment Reminder Preference

I ________________________ would prefer to be notified of my appointments / the appointments for

___________________________via:

Patient Name

( ) Automated phone call from Atlantic Psych Associates to ____________________________.

Phone number

( ) Text message from Atlantic Psych Associates to _________________________.

Phone number

My cell carrier is: AT&T Metro PCS Sprint T-Mobile Verizon Other _____________

Print name of carrier

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.

____

Print Name

___________________________________ ______________

Signature Date

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 CRF 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	Problem	Psychiatrist, Therapist	How long?	Medication Prescribed? (dosage, frequency)

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?_____________________________________
Are there any special services at school now or before? Describe: ______________________

Atlantic Psych Associates

Medical History:

Regular medications:

Allergies to medications?	Ear Infection(s)?	Heart Trouble?
Asthma?	Hearing/Vision trouble?	Epilepsy?
Head Injury?	Tics?	Soiling/Wetting Bed?

Surgery? If yes, please describe:____________________________________

History of Abuse? Describe:

Family History of biological parents, full siblings, and full uncles, aunts, and grandparents:

ADHD	Alcohol/Drug Abuse	Repeated Arrests	Tics
Schizophrenia	OCD	Bipolar	
Depression	Suicide	Dyslexia	

Other: ____

Highest school grade completed by birth parents: Father: Mother:

Regarding pregnancy history of this child, did the birth mother use Alcohol, Tobacco, Cocaine, or other drugs? . Circle those that apply.

Was there Post-partum Depression? How severe?

Mother's health during pregnancy: (circle one) Good Fair Poor

Was there any illness/complications during pregnancy? (e.g., RH neg., toxemia, diabetes)

Delivery:
Length of pregnancy: ______months Birth complications?

Did the Infant have: Colic Could your child be soothed or calmed?

Would not Cuddle Would not Sleep Would not Eat

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 you 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:

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

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

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FINANCIAL AGREEMENT

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.

I would like to keep a credit card on file. I understand that this car will be charged for the cost of my appointment or co-pay, if using insurance, AT THE TIME OF SERVICE. No charge will be made toward outstanding balances without my additional consent. We only accept: VISA, MASTERCARD, and DISCOVER.

Printed name:____

Signature____ Date:_________

Credit card number:____

Expiration:_______________ Security code:___________________

Name as it appears on the card:____

Zip Code where you receive the credit card bills: ________________

______ I do not request a receipt ________ I do want a receipt

PLEASE PRINT CLEARLY. Thank you.

Atlantic
Psych Associates

Telehealth Informed Consent

1. I, _________________________________, understand that telehealth services are completely voluntary and I can end the session at any time.

2. I understand that none of the telehealth sessions will be recorded.

3. I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

4. I understand that telehealth is performed over a secure communication system that is HIPPA compliant. I accept the risk that a technological breach could affect confidentiality.

5. My therapist has explained to me how video conferencing technology procedures will be used. I understand that any telehealth sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.

6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions if it is felt that the videoconferencing is not adequate for my situation.

7. I understand that I may experience benefits from the use of telehealth, but that no results can be guaranteed or assured.

8. I understand that if the video conferencing connection drops while I am in a session and I cannot reconnect, I should contact the office of Atlantic Psych Associates to establish a secondary method of contact or to reschedule my appointment.
9. I understand that this form is signed in addition to the Information, Authorization, and Consent to Treatment document and that all other policy and procedure documents I have completed apply to telehealth services.

10. I understand that I am still responsible for any co-pays or deductibles for my session, and that they will be charged to the credit card I have on file at the time of the appointment.

11. I understand that I am responsible to make sure that telehealth is a covered benefit under my insurance. I understand that I am responsible for payment if my insurance will not cover the session.

12. I understand that Atlantic Psych Associates is not liable for any breaches in privacy or confidentiality that is due to problems based from the electronic device used by me or by my location. Some applications specifically interact via phone / tablet, device, etc. and have the capability to report activity, gps location, etc. This also includes others overhearing you at your location, others using your electronics, or by stolen or hacked electronics.

13. I understand that I am responsible for providing the necessary telecommunications equipment and internet access for my telehealth sessions, the security on my computer, and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.

14. I understand I have the right to withhold or withdraw this consent at any time.

15. I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment documents that I have previously signed.

____	________________
Signature of client or guardian	Date
____	______________________________
Printed name of client or guardian	Name of client (if signed by guardian)

I would like my link to my telehealth session to be sent via (pick one):

-email: ____________________________________
E-mail address

-text message : ______________________________
Phone number