

Jeff M. Bauman, Psy.D., P.A., and Associates

Application for Services and Financial Policies –C/A

PLEASE answer as complete as possible.

Date _____ Please tell us who referred you _____

Child/Adolescent Complete Name: _____

Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone _____ Wk. Phone Dad _____ Wk. Phone Mom _____

Are there any restrictions as to where we may phone
parent/guardian? _____

May we contact parent/guardian by E-Mail? _____ If so, E-Mail address _____

Insurance I.D.: _____

Father's name _____ Age _____ Education _____

Father's place of employment _____

Father's type of employment _____

Mother's name _____ Age _____ Education _____

Mother's place of employment _____

Mother's type of employment _____

Is child/adolescent adopted? Yes No If yes, age when
adopted _____

Are parents married? Yes No Separated? Yes No
Divorced? Yes No

If parents are divorced has either parent remarried? Yes No

Explain _____

Do both parents agree to this evaluation/treatment? Please
explain. _____

Previous mental health professional/provider _____

Primary physician: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Child/Adolescent's Complete Name_____

What brings you/your child in for treatment at this time?

How long have the difficulties been present?_____

What are your goals for treatment?_____

I hereby apply and consent to psychological services/consultation with Dr. Bauman and Associates. I understand that it is my responsibility to cooperate with treatment.

Signature_____ Date_____

I authorize payment of medical benefits to Dr. Bauman for services provided. Dr. Bauman has permission to send billing information to my insurance carrier.

If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment. All follow-up with the insurer is the responsibility of the insured.

Signature_____ Date_____

Charges for services are due and payable at the time services are rendered. If you have health insurance, it should be understood that this is an agreement between you and your carrier. You remain directly responsible to the doctor for your account. If you fail to meet your financial responsibilities, we reserve the right to turn your account over to a collection agency or appropriate court.

I hereby give my consent to release necessary information for taking such action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.

Signature_____ Date_____

PLEASE BE SURE TO READ YOUR COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES and HIPAA PRIVACY NOTICE! Please take it with you for your records.

I have read and understand the Patient's Rights and Responsibilities and HIPAA. I have received a copy for my records.

Signature_____ Date_____

Witness_____ Date_____

Child's/Adolescent's Name _____

Please complete the following information as best you can. This allows for more efficient and effective use of your first session.

Child/Adolescent's SYMPTOMS INCLUDE (Circle all that apply)

Depression Anxiety Insomnia Sadness Crying Spells Impulsive
Suicidal Thoughts No pleasure No Energy Alcohol abuse Pain
Can't sit still Can't concentrate Can't Work Can't eat Eating too much
Sleeping too much Worrying too much Weight loss Weight gain Drug abuse
Headaches Troubling thoughts Feeling paranoid Feeling out of control
Thoughts to harm others Distrustful Fearful Oppositional Behavior Explosive
outbursts Educational difficulties Homework battles

Others that we have not mentioned _____

MENTAL HEALTH HISTORY (Include dates/providers of any hospitalizations and outpatient treatment) _____

FAMILY MENTAL HEALTH HISTORY (Please list all blood relatives who have a documented or suspected psychiatric problem, including addictive disorders) _____

Child/Adolescent Name _____

Developmental and Medical History

PREGNANCY AND DELIVERY

- A. Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) _____
- B. Length of delivery (number of hours from initial labor pains to birth) _____
- C. Mother's age when child was born _____
- D. Child's birth weight _____

Did any of the following conditions occur during pregnancy/delivery?

- 1. Bleeding _____ NO YES
- 2. Excessive weight gain (more than 30 lbs.) _____ NO YES
- 3. Serious illness or injury _____ NO YES
- 4. Took prescription medication (which? _____) _____ NO YES
- 5. Used alcoholic beverages (how many drinks per week _____) _____ NO YES
- 6. Used recreational drugs _____ NO YES
- 7. Smoked Cigarettes (how many packs per day? _____) _____ NO YES
- 8. Forceps used during delivery _____ NO YES
- 9. Breech delivery _____ NO YES
- 10. Other problems-please describe _____

Did your child have any difficulties during delivery or within the first few days after birth?

INFANT HEALTH AND TEMPERAMENT

During the first 12 months, was your child:

- 1. Difficult to feed _____ NO YES
- 2. Difficult to get to sleep _____ NO YES
- 3. Colicky _____ NO YES
- 4. Difficult to put on a schedule _____ NO YES
- 5. Alert _____ NO YES
- 6. Cheerful _____ NO YES
- 7. Affectionate _____ NO YES
- 8. Sociable _____ NO YES
- 9. Easy to comfort _____ NO YES
- 10. Difficult to keep busy _____ NO YES
- 11. Overactive, in constant motion _____ NO YES

Child's/Adolescent's name _____

EARLY DEVELOPMENTAL MILESTONES

At what age did your child first accomplish the following?

1. Sitting without help _____
2. Crawling _____
3. Walking without assistance _____
4. Using single words _____
5. Putting two or more words together _____
6. Bowel training, day and night _____
7. Bladder training, day and night _____

HEALTH HISTORY

Date of child's last physical exam: _____

At any time has your child had the following?

- | | <u>Never</u> | <u>Past</u> | <u>Present</u> |
|--|--------------|-------------|----------------|
| 1. <u>Asthma</u> _____ | | | |
| 2. <u>Allergies (to what? _____)</u> _____ | | | |
| 3. <u>Diabetes</u> _____ | | | |
| 4. <u>Epilepsy or seizure disorder</u> _____ | | | |
| 5. <u>Heart or blood pressure problems</u> _____ | | | |
| 6. <u>Broken bones</u> _____ | | | |
| 7. <u>Surgery</u> _____ | | | |
| 8. <u>Head injury with loss of consciousness</u> _____ | | | |
| 9. <u>Lengthy hospitalization</u> _____ | | | |
| 10. <u>Speech or language problems</u> _____ | | | |
| 11. <u>Chronic ear infections</u> _____ | | | |
| 12. <u>Hearing difficulties</u> _____ | | | |
| 13. <u>Vision problems</u> _____ | | | |
| 14. <u>Fine motor/handwriting problems</u> _____ | | | |
| 15. <u>Gross motor difficulties/clumsiness</u> _____ | | | |
| 16. <u>Appetite disturbance</u> _____ | | | |
| 17. <u>Sleep problems</u> _____ | | | |
| 18. <u>Soiling problems</u> _____ | | | |
| 19. <u>Wetting problems</u> _____ | | | |
| 20. <u>Other health difficulties-please describe</u> _____ | | | |

Current Medications:

Prescribed by:

Allergies:
