

Jeff M. Bauman, Psy.D., P.A.
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 Mom _____ Wk. Phone Dad _____

Are there any restrictions as to where we may phone or leave message for parent/guardian? _____

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

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? _____ If yes, age when adopted _____

Are parents married? _____ Separated? _____ Divorced? _____

If parents are divorced has either parent remarried? _____

Please explain as needed: _____

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 certify that I am the legal parent or guardian of the identified patient and that **I have the right to independently seek medical/psychological treatment for this child.** If there is another party who needs to agree. I certify that I have notified that party and they agree to this treatment. I understand that it is my responsibility to cooperate with treatment.

Parent/Guardian Signature _____ Date _____

Charges for services are due and payable at the time services are rendered. This practice does not bill nor interact directly with insurance companies. You remain directly responsible to the practice 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.

In the unlikely event that I do not meet my financial obligation, I hereby give my consent to release necessary information for taking collection action. I understand that I will be responsible for any expenses incurred due to collection or judicial actions in this regard.

Signature _____ Date _____

I understand that it is my responsibility to provide at least ***48 hours notice*** during business hours in order to cancel or reschedule an appointment. The practice will charge full fee for appointments cancelled or missed without this notice.

Signature _____ Date _____

PLEASE BE SURE TO READ YOUR COPY OF PATIENT'S RIGHTS AND RESPONSIBILITIES and HIPAA PRIVACY NOTICE! These are always available on our websites. WestonChildPsychologist.com or FloridaADHD.com

I have read and understand the Patient's Rights and Responsibilities-2018 and HIPAA.

Signature _____ 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

Depression Anxiety Worry Sadness Crying Spells Impulsive Oppositional Behavior
Suicidal Thoughts No pleasure No Energy Tearfulness Difficulty making/keeping friends
Can't sit still Can't concentrate Can't eat Eating too much Headaches Stomach Issues
Sleep issues Weight loss Weight gain Drug use Alcohol use
Toilet(elimination) issues Troubling thoughts Feeling paranoid Feeling out of control
Thoughts to harm others Distrustful Fearful Explosive outbursts
Educational difficulties Homework battles Lack of Motivation Decreased school grades
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 _____

2. Excessive weight gain (more than 30 lbs.) _____

3. Serious illness or injury _____

4. Took prescription medication (which?) _____ 5. Used alcoholic beverages (how many drinks per week _____) **NO** YES

6. Used recreational drugs _____

7. Smoked Cigarettes (how many packs per day?(_____)

8. Forceps used during delivery _____

9. Breech delivery _____

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? _____

2. Difficult to get to sleep _____

3. Colicky _____

4. Difficult to put on a schedule _____

5. Alert _____

6. Cheerful _____

7. Affectionate _____

8. Sociable _____

9. Easy to comfort _____

10. Difficult to keep busy _____

11. Overactive, in constant motion _____

Child's/Adolescent's name _____

EARLY DEVELOPMENTAL MILESTONES (AS MUCH AS YOU CAN REMEMBER)

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?

1. Asthma _____
2. Allergies (to what?) _____
3. Diabetes _____
4. Epilepsy or seizure disorder _____
5. Heart or blood pressure problems _____
6. Broken bones _____
7. Surgery _____
8. Head injury with loss of consciousness _____
9. Lengthy hospitalization _____
10. Speech or language problems _____
11. Chronic ear infections _____
12. Hearing difficulties _____
13. Vision problems _____
14. Fine motor/handwriting problems _____
15. Gross motor difficulties/clumsiness _____
16. Appetite disturbance _____
17. Sleep problems _____
18. Soiling problems _____
19. Wetting problems _____
20. Other health difficulties-please describe _____

Current Medications: _____ Prescribed by: _____

Allergies: _____

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

HIPAA CONSENT

This form is an agreement between you and this practice. When we use the word "you" below, it can mean you, your, child, a relative, or other person if you have written his/her name here Patient Name)_____.

Your signature here certifies your consent that we may use/share your Protected Health Information as described in the HIPAA PRIVACY NOTICE you have received. Please make sure to read that document and ask us any questions. Additionally I am asking your consent to communicate with the treatment team. This team consists of other healthcare professionals such as your pediatrician or psychiatrist during the treatment episode.

After you have signed this consent, you have the right to revoke it (by writing a letter to Dr. Bauman). We will then comply with your wishes from that time forward. Of course we cannot do anything about information shared previous to your revocation.

Signature of patient or his/her personal representative

Date

Printed name of patient or personal representative

Date

Relationship to patient