CHILD AND FAMILY PSYCHIATRIC CENTER

1744 E. McAndrews Rd., Suite B. - Medford, Oregon 97504
Phone (541)776-0821 FAX (541)776-5011

PATIENT REGISTRATION

Welcome to Child and Family Psychiatric Center.
Please complete all forms and bring them with you to your upcoming appointment.

PATIENT DEMOGRAPHICS

Client's Name: ____ Today's Date: ____________________

Partner's Name: (If being seen as a couple): ____
**if you would like this person to be able to discuss your care and/or billing issues, please complete an Authorization to Release and Exchange Mental Health Information form.

Mailing Address: _____________________________City: ___________ State:________ Zip:_______________

Telephone(s) _______________________ ___________________ Email ________________________________
(Best contact number)

May we leave messages for you on phone? Yes or No   May we email you? Yes or No

Gender: M ___ F ___ Age: ___ Date of Birth:_______________ Marital Status_____________________________

Others living in the home: _________________________________ , __________________________________
(name, birth date, relationship to client)   (name, birth date, relationship to client)

Education: Self _______________________________ Partner: _______________________

Occupation: Self ______________________________ Partner: ________________________

Social Security Number: _________________________ Partner: _______________________

Emergency contact: ____ Phone: ___________________

Referred by: ____ Phone: ___________________

INSURANCE INFORMATION

Primary Insurance: _____________________________________ Policy #: _______________________________

Policyholder Name: ______________________________________ Date of Birth: __________________________

Secondary Insurance: ___________________________________ Policy #: _______________________________

Policy Holder Name: ______________________________________ Date of Birth: _________________________

Assignment and Release:

I, the undersigned, have insurance coverage with _______________________________________ and assign to Child and Family Psychiatric Center of Southern Oregon and/or ______________________________, all medical benefits, if any, otherwise, payable to me for services rendered. I agree to be responsible for and to make all payments for services and treatment. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize Child and Family Psychiatric Center of Southern Oregon to release all information necessary to secure the payment of benefits. I authorize use of this signature on all my insurance submissions.

____
Patient Signature / Authorized signature   Relationship to Patient

____
Print Name   Today's Date

Child and Family Psychiatric Center

ADULT INITIAL BACKGROUND QUESTIONNAIRE – page 1
CONFIDENTIAL

Name of Patient: ________________________________ DOB __________________ Age ____________

Briefly describe the problems that brought you here today: ______________________________________

____

____

____

____

Primary reason for seeking services: Therapy ☐ Medication ☐ Both ☐

Please check all the symptoms you are having:

- ☐ Distractible
- ☐ Impulsive
- ☐ High Energy
- ☐ Talks non-stop
- ☐ Problems with peers
- ☐ Trouble with organization
- ☐ Anger outbursts
- ☐ Steals
- ☐ Annoys others
- ☐ Blames others
- ☐ Refuses to comply
- ☐ Aggressive/Violent
- ☐ Fire-setting
- ☐ Harms animals
- ☐ Sudden feelings of panic
- ☐ Alcohol/drug abuse
- ☐ Problems with family
- ☐ Running away
- ☐ Depressed/extreme sadness
- ☐ Feels hopeless
- ☐ Low self-esteem
- ☐ Isolation/Withdrawal
- ☐ Problems eating
- ☐ Easily tearful
- ☐ Extreme sadness
- ☐ Lack of energy
- ☐ Memory problems
- ☐ Thoughts of self-harm
- ☐ Has hurt or tried to hurt self
- ☐ Weight/Appetite changes
- ☐ Thoughts of harming others
- ☐ Feeling fearful
- ☐ Irritability
- ☐ Problems with sleep
- ☐ Headaches; Stomachaches
- ☐ Trouble concentrating
- ☐ Lots of worries
- ☐ Nervousness
- ☐ Perfectionistic
- ☐ Bed-wetting
- ☐ Feelings of guilt
- ☐ Problems separating from caregiver
- ☐ Problems eliminating bowels/bladder
- ☐ Speech and language problems

Have you been in counseling in the past? ☐Yes ☐No

If yes, with whom ___________________________ Start and End Date: ______________________________

Have you been prescribed or have taken any medications, including over-the-counters? ☐Yes ☐No

If yes, what? (use additional paper as needed) ____

Reason: ____

____

Substance Abuse History

Do you use tobacco?	☐ Current	☐ Suspected	☐ Past	☐ No
Do you use alcohol?	☐ Current	☐ Suspected	☐ Past	☐ No
Do you use caffeine?	☐ Current	☐ Suspected	☐ Past	☐ No
Do you use recreational drugs?	☐ Current	☐ Suspected	☐ Past	☐ No

Child and Family Psychiatric Center

ADULT INITIAL BACKGROUND QUESTIONNAIRE – page 2
CONFIDENTIAL

Medical Information

Who is your Primary Care Physician? ____

Have you seen the doctor in the past year? ☐Yes ☐No Reason ________________________________

____

How is your general health? ☐Very good ☐Good ☐Fair ☐Poor

Have you had any chronic illnesses? ☐Yes ☐No If yes, what? ____________________________

Do you have any allergies? ☐Yes ☐No If yes, what? ____________________________________

Family History

Please check all of the concerns/diagnoses present on the mother's side of the family ☐Unknown

☐Drug Addictions/Alcoholism ☐Suicide ☐Depression ☐Bipolar Disorder
☐Obsessive Compulsive Disorder ☐Severe Anxiety ☐Trauma ☐ADHD
☐Learning Problems ☐Schizophrenia ☐Autism ☐Other: _______________________

Please check all of the concerns/diagnoses present on the father's side of the family ☐Unknown

☐Drug Addictions/Alcoholism ☐Suicide ☐Depression ☐Bipolar Disorder
☐Obsessive Compulsive Disorder ☐Severe Anxiety ☐Trauma ☐ADHD
☐Learning Problems ☐Schizophrenia ☐Autism ☐Other: _______________________

Additional Information

Child and Family Psychiatric Center

POLICY ON PATIENT ACCOUNTS

****PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED****

- **Insurance Billing**

As a courtesy to you we will bill your primary insurance, and also your secondary, if the appropriate information is provided to us at the time of service. It is ultimately your responsibility to follow up with them to make sure your account is paid. **We require co-pays at the time of service**, and are able to accept cash, checks, Visa and MasterCard If we are unable to verify your insurance or you do not present with the correct insurance information you will be responsible for any and all charges incurred. This office does not bill Medicare or the Oregon Health Plan.

___________ (initials)

- **Self-Pay Patients**

Payment is due in full at time of service.

___________(initials)

- **Payment Arrangements**

If you are unable to pay at the time of the appointment, please contact this office **prior** to appointment to make arrangements.

___________ (initials)

- **Statement Processing Fee**

A monthly statement processing fee of $2.50 will be accrued for each month a statement must be sent. ___________(initials)

- **Delinquent Accounts**

If you are not able to make payments as agreed and your account becomes delinquent, the account may be turned over to a collection agency. Delinquent accounts are subject to dismissal from our practice.

___________ (initials)

- **Divorce Decrees**

Minor patients only. CFPC is not a party to your divorce decree. We will not be involved in mediating financial arrangements between parents/guardians. The signed party responsible for the account prior to the divorce or separation remains responsible for the account.

___________ (initials)

- **Non-Sufficient Funds**

A $35 fee will be added to your account for any checks returned due to a non-sufficient fund (NSF). If we receive a NSF we will no longer accept checks for payment – only cash or Visa/MasterCard. You agree to be responsible for NSF charges even if the check is written by another party.

- **Late Cancels and No-Shows** ___________(initials)

A minimum fee of $25.00, up to the full price of the appointment for time reserved, may be charged to your account for missed appointments or appointments canceled less than 24 hours in advance. Excessive no shows or missed appointments are subject to dismissal from our practice.
The above charges will not be submitted to insurance.

___________ (initials)

____

Patient Signature or Authorized Signature — Relationship to Patient

____

Printed Name of Patient — Date of Birth — Date

Child and Family Psychiatric Center

ACKNOWLEDGMENT AND CONSENT

I understand that Child and Family Psychiatric Center (referred to below as "CFPC") will use and disclose **mental health information** about me.

I understand that my **mental health information** may include information both created and received by CFPC, may be in the form of written records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that CFPC may **use and disclose** my mental health information in order to:

- » Make decisions about and plan for my care and treatment;
- » Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- » Determine my eligibility for insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some of all of my health care; and
- » Perform various office, administrative and business functions that support my physicians efforts to provide me with, arrange and be reimbursed for quality health care.

I also understand that I have the right to receive and review a written description of how CFPC will handle mental health information about me. This written descriptions is known as a **Notice of Privacy Practices** and describes the uses and disclosures of mental health information made and the information practices followed by the employees, staff and other office personnel of CFPC, and my rights regarding my mental health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of CFPC's Notice of Privacy Practices in effect will be posted in waiting / reception areas.

I understand that I have the right to ask that some or all of my mental health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that CFPC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: ______________________________________ Date: ___________________________

(Patient Signature)

Patient Name: _______________________________ Date of Birth: _____________________

By: ______________________________________ Date: ___________________________

(Patient Representative)

Child and Family Psychiatric Center

OFFICE POLICY

OUR MISSION

"Bringing together expert clinicians from every mental health discipline and providing excellent, integrated treatment to the children, teens and working age adults in our region. We always strive to deliver up-to-date, comprehensive care to heal and empower all those we serve."

Office Hours

Child and Family Psychiatric Center office hours are Monday through Friday from 9:00 am to 5:00 pm. Each individual practitioner's hours may vary. Some early morning and later evening appointments are available.

All appointments are booked through our receptionist in person or by calling our office at (541)776-0821. You will always be seen as promptly as possible. To insure that you are here on the proper day and time, please check in with our receptionist upon your arrival. If you find you must cancel your appointment, we require that you inform us at least 24 hours before the scheduled appointment time.

After Hours

Child and Family Psychiatric Center is not a crisis center, if you are experiencing a life threatening emergency dial 911 or go to the Rogue Regional Medical Center Emergency Room. We do have an after hours phone service that can be reached by dialing our main number at (541)776-0821 and pressing 0 when prompted, an operator will locate your doctor or therapist.

Prescription Refills

Please call your pharmacy at least 2 working days in advance when a prescription requires refilling. This will allow sufficient time for the pharmacy to contact the doctor for his/her authorization to refill your prescription. If your prescription requires it be on paper then please allow us 1-2 business days to complete this for your by calling our office at (541)776-0821. Prescriptions and refills are issued during office hours only. Our physicians do not routinely write prescriptions or issue refill requests during the evenings or weekends because your medical records are not available.

Referrals

We are proud to offer a multidisciplinary team to handle your mental health care needs. Interoffice referrals are available for medication management and counseling. Ask your provider or our office staff for information on other services provided at our office.

Contact Us

Our office is located at 1744 E. McAndrews Rd., Suite B Medford, Oregon 97504.
Office phone number (541)776-0821. Office FAX number (541)776-5011. E-mail address staff@childfpc.com.
Website: www.childandfamilypsychiatriccenter.com

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