

**CEDAR CREEK ASSOCIATES LLC**  
**CHILD PATIENT INFORMATION**

Date: \_\_\_\_\_ Clinician/Provider: \_\_\_\_\_

Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Local Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Is it Ok to contact you via (circle answer): Email: Yes No Email: \_\_\_\_\_ Text: Yes No

<u>Phone</u> : Yes NO	<u>Cell</u> : Yes NO	<u>Work</u> : Yes NO
Home Phone: _____	Cell Phone: _____	Work Phone: _____

Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Student: \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Not in School: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell	Work
Home Phone: _____	Phone: _____

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES** I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Name of Responsible Party

**The Complete Notice of Privacy Practices is located in our waiting room. It is also on our website Cedarcreekassociates.com under Privacy Act.**

# CONSENT TO TREATMENT

By signing the document below, you assert that you have read and understand this page, and that you consent to treatment for yourself, your minor child, or your family. I will be happy to discuss any questions or concerns you may have.

## CONFIDENTIALITY

What we talk about, and even the fact that you are coming here for treatment, is private information and cannot be disclosed except under the following circumstances:

- If you give me a signed authorization to release the information;
- If I have reason to think you may be an immediate danger to yourself or to others;
- If a court orders me to release the information;
- In order to collect fees, information can be released to the third party payor;
- To other professionals for consultation (in which case your identity will not be disclosed);
- To qualified personnel for management or financial audits (an insurance company audit, for example).

## THE NATURE OF PSYCHOTHERAPY

I will use traditional verbal techniques in providing therapy to you, or traditional play therapy techniques with your child. Treatment planning requires an assessment and diagnosis. If you have questions about the diagnosis or the diagnosis process, please ask me.

Some questions that I will ask will be very personal and may cause you more anxiety. Please feel free not to answer, or to talk to me about your feelings about the issue. I may ask you to carry out an assignment outside of the therapy hour. If so, the assignment is intended to help you, but if you feel uncomfortable with it or think it may be harmful in any way, please do not carry it out and do talk with me about your concerns.

I will see you by appointment in my office. If I see you outside the office, I will be friendly, but will not discuss your issues nor indicate the nature of our relationship unless you make it clear that you want the relationship known.

Psychotherapy is not an exact science. It involves a cooperative effort between us. I encourage your questions and open participation. Please discuss with me any questions or concerns about our work, the staff, or the facility. Psychotherapy is intended to address the problems you present and that we agree to work on together. There is a possibility that therapy can make problems worse or even create new problems. Usually, this is a stage toward getting better, but if you do not understand how what we are doing can help, please talk to me about it.

## TERMINATION

It is usually most beneficial for therapist and client to discuss the termination process and I encourage you to do so. However, if I have had no contact with you for two months, your case will be automatically terminated. It is always easy to re-open a case, so we can do so if you contact me again.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Name of Responsible Party

# FINANCIAL POLICIES

Thank you for choosing me as your therapist. Your treatment involves payment for services. Please read this statement of my financial policies carefully, and sign it to show that you have read and understand it.

Fees are charged for the following:

- Therapy sessions (individual, family, couples, or group)
- Non-cancelled appointments or those missed without 24 hour prior notice
- Preparing/copying records, reports, and letters
- Telephone consultations
- Returned checks
- Interest may be added to accounts due for 90 days
- Court appearances, depositions, travel and preparation time (ask for my legal policy)
- If an account is sent to collection, the fee will be what the collection agency charges plus any legal fees necessary to collect.

Please note:

- Payment is expected at the time of service
- Payment plans are available with prior notice

About Cedar Creek Associates: Cedar Creek Associates is an office-sharing LLC only. It is not a group clinical practice. Each associate maintains his or her own independent practice. No other professional relationship exists among the clinicians.

Regarding Insurance: I may accept assignment of benefits once you provide needed information. This means that you would pay co-pays and deductibles at the time of service and the staff will bill the insurance company for the balance. When we tell you what the benefits and authorizations for sessions are, we cannot guarantee that the information is correct. I am providing you with an estimate of your share of the cost treatment as provided to me by your managed care company, insurance company, or employee assistance program. Sometimes this information is not consistent with later information we receive from the insurance company. Your actual share may be more than this estimate. You are ultimately responsible for the charges. Remember to please let me know if you change insurance or managed care companies.

Managed care companies: Many insurance companies contract with a managed care company to manage the benefits and care. The managed care company may require that I obtain prior authorization for sessions and I usually am required to submit clinical information about you to do so.

By signing below, you authorize me to bill your EAP or Managed Care Company, and you authorize the payer to pay me directly.

*Thank you. If you have any questions or concerns about these policies, please speak with me or with one of the office staff.*

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Name of Responsible Party

**THE PURPOSE OF THIS RELEASE IS TO ALLOW YOUR THERAPIST TO BILL YOUR INSURANCE COMPANY AND OBTAIN AUTHORIZATION FOR TREATMENT.**

Patient's Name (print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. I authorize the following person: \_\_\_\_\_ (Name of therapist)
2. To use or disclose the information below from the initial date of service until financial liabilities are satisfied.
  - \_\_\_\_\_ Inpatient or outpatient treatment records for physical or psychological, psychiatric, or emotional illness.
  - \_\_\_\_\_ Admission and discharge summaries.
  - \_\_\_\_\_ Psychological, psychiatric, and or medical evaluations, reports, histories, assessments, treatment notes, treatment plans, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or documents received from other medical and mental health providers.
  - \_\_\_\_\_ Billing records.
3. Name of your insurance company and/or Employee Assistance Program: \_\_\_\_\_
4. I understand and agree that this authorization will be valid and in effect until service with this provider is completed and payment of benefits have been collected. I understand that after this date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.
5. I understand that I can revoke or cancel this authorization at any time by sending a letter to my provider. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that time.
6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Provider named above, nor will it affect my eligibility for benefits. However, I may not be able to have further sessions authorized other than those contained in the initial authorization of services and I will assume financial responsibility for all subsequent services.
7. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.
8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
9. I have discussed the issues above with the Provider and I understand the terms of this authorization.

\_\_\_\_\_  
Signature of client or his/her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name above

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Description of the personal representative's authority

**CEDAR CREEK ASSOCIATES**  
Private, Independent Practitioners

**CHILD QUESTIONNAIRE**

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Please list any person living in the child's home:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list other immediate family members not currently living in the child's home:

Name	Age	Relationship	Quality of Relationship
_____	_____	_____	_____
_____	_____	_____	_____

Mother's occupation: \_\_\_\_\_ Father's occupation: \_\_\_\_\_

Approximate family income: \_\_\_\_\_ Family's religion: \_\_\_\_\_

If the child was adopted, at what age? \_\_\_\_\_ Does the child know he/she was adopted? \_\_\_\_\_

Age when told about the adoption? \_\_\_\_\_ Has the child had any contact with the biological parents since the adoption? \_\_\_\_\_

Does the child mention the biological parents? \_\_\_\_\_

**EDUCATIONAL INFORMATION:**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Does the child seem to like his or her teacher? \_\_\_\_\_

Has the child ever failed a grade or been held back? If so, please explain: \_\_\_\_\_

Has the child ever received special education, special resource, or speech services? Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

**MEDICAL INFORMATION:**

Physician: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Please list any illnesses or medical conditions: \_\_\_\_\_

List any medication to which the child is allergic: \_\_\_\_\_

Please list any medications the child takes:

Medication	Amount of Dose	Frequency	Purpose of Medication

Please check and explain any concerns or events from the list below:

- \_\_\_ The child's weight or diet: \_\_\_\_\_
- \_\_\_ Has the child ever been unconscious from a head injury? \_\_\_\_\_
- \_\_\_ Has the child ever been neglected, traumatized, or abused? \_\_\_\_\_
- \_\_\_ Has the child had previous counseling or testing? \_\_\_\_\_
- \_\_\_ Has the child ever been hospitalized? \_\_\_\_\_
- \_\_\_ Has the child tried or used drugs, tobacco, or alcohol? \_\_\_\_\_
- \_\_\_ Does the child drink caffeine (soda, tea, coffee) and how much? \_\_\_\_\_

Has any person in the child's biological family ever:

- \_\_\_ Had depression? \_\_\_\_\_
- \_\_\_ Had schizophrenia? \_\_\_\_\_
- \_\_\_ Committed suicide? \_\_\_\_\_
- \_\_\_ Had an anxiety disorder? \_\_\_\_\_
- \_\_\_ Been hospitalized for a psychiatric illness? \_\_\_\_\_
- \_\_\_ Had a problem with alcohol or drug abuse? \_\_\_\_\_
- \_\_\_ Had bipolar or manic-depressive disorder? \_\_\_\_\_
- \_\_\_ Been imprisoned for a felony? \_\_\_\_\_
- \_\_\_ Had a learning disability or ADHD? \_\_\_\_\_

Has the child ever been the victim of a crime? If so, please explain:

\_\_\_\_\_

**SOCIAL/RECREATIONAL INFORMATION:**

Please list the child's hobbies and interests: \_\_\_\_\_

How well does the child get along with peers? \_\_\_\_\_

- Does the child have a best friend? \_\_\_\_\_
- Does the child have a TV in the bedroom? \_\_\_\_\_
- Estimate the number of hours per week the child watches TV: \_\_\_\_\_
- Estimate the number of hours per week the child plays video or computer games: \_\_\_\_\_
- Does the child have access to the internet? \_\_\_\_\_
- Do you restrict access to the internet, games and/or movies with violent or sexual content? \_\_\_\_\_

Name: \_\_\_\_\_

**PRESENTING PROBLEM:**

Please explain why you are seeking treatment for your child: \_\_\_\_\_

\_\_\_\_\_

How severe are these concerns to you?      \_\_\_\_\_ Mild      \_\_\_\_\_ Severe      \_\_\_\_\_ Extremely severe

How severe are these concerns to the child:      \_\_\_\_\_ Mild      \_\_\_\_\_ Severe      \_\_\_\_\_ Extremely severe

When did the problem(s) begin? \_\_\_\_\_

What have you done to try and solve the problems? \_\_\_\_\_

Please check any symptoms your child is having:

- |                               |                                      |                       |
|-------------------------------|--------------------------------------|-----------------------|
| _____ Tiredness               | _____ Difficulty sleeping            | _____ Increased tears |
| _____ Argues a lot            | _____ Loss of interest in activities | _____ Nervousness     |
| _____ Irritability            | _____ Withdrawal from others         | _____ Clinging        |
| _____ Worries a lot           | _____ Changed eating habits          | _____ Destructive     |
| _____ Refuses to go to school | _____ Hurts self or talks about it   | _____ Poor attention  |
| _____ Aggressive behavior     | _____ Hurts others or talks about it | _____ Nightmares      |
| _____ Soils or wets self      | _____ Grades have dropped            | _____ Over sleeps     |
| _____ Rude to parents         | _____ Won't follow instructions      | _____ Disobedient     |

Strange ideas: \_\_\_\_\_

Other: \_\_\_\_\_

Please check any recent changes the child has experience:

- |   |   |                        |
|---|---|------------------------|
| _____ Illness or injury                 | _____ Family moved                      | _____ Friend moved     |
| _____ Sibling left home                 | _____ New family member                 | _____ Parent left home |
| _____ Loved one died                    | _____ Experienced or witnessed violence | _____ Parents divorced |
| _____ Child moved into/away from family |   |                        |

Other major loss or event: \_\_\_\_\_

Other: \_\_\_\_\_

Name: \_\_\_\_\_

I give permission to \_\_\_\_\_ to treat my child \_\_\_\_\_ in psychotherapy. I am the custodial parent or legal guardian of the child and I have the legal authority to authorize Treatment. I understand that I am financially responsible for fees incurred in this treatment.

\_\_\_\_\_ Without the consent of anyone else.

\_\_\_\_\_ Only with the consent of:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address (number and street)

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Phone Number

\_\_\_\_\_ I agree to provide any necessary documentation.

I understand that no child custody evaluation will be performed and that therefore my therapist will not formulate an opinion regarding any custody issues, and that requiring the therapist to testify regarding custody issues would be harmful to my child and the therapeutic relationship.

\_\_\_\_\_  
Printed name of parent or guardian

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date

*Thank you for selecting me as your child's therapist. Please feel free to discuss any concerns you may have about your child's treatment. At any time that I am alone with your child, you are invited to open the door and check on your child's well-being. The ending of therapy is as important to children as what takes place within it and I request that you talk with me about how therapy will terminate before we actually end.*



## DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Date: \_\_\_\_\_

Relationship with the child: \_\_\_\_\_

**Instructions (to the parent or guardian of child):** The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)					
During the past <b>TWO (2) WEEKS</b> , how much (or how often) has your child...												
I.	1.	Complained of stomachaches, headaches, or other aches and pains?					0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?					0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?					0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?					0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?					0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?					0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?					0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?					0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?					0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?					0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?					0	1	2	3	4	
	12.	Not been able to stop worrying?					0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?					0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?					0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?					0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?					0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?					0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?					0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?					0	1	2	3	4	
In the past <b>TWO (2) WEEKS</b> , has your child ...												
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
XII.	24.	In the past <b>TWO (2) WEEKS</b> , has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know			

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