Child and Adolescent Health Specialists, PC

223 Chief Justice Cushing Highway, Suite 201
Cohasset, MA 02025
T. 781.383.8380
F. 781.383.8382

A New Day In Pediatrics

PATIENT REGISTRATION FORM FOR COUNSELING

Child's First	Middle	Last Name	Date of Birth	Age	Sex

Street Address	City	State	Zip

Preferred Phone # (for office to contact you) Ok to leave messages Voice ❑ or Text ❑	How did you hear about us? ❑ Mailing ❑ Newspaper ❑ Internet ❑ Other _____ ❑ Physician _____ ❑ Family/Friend _____

Mother's Name	Father's Name	Parent's Marital Status S M D W

Legal Guardian (if different from above) or if divorced who has legal and physical custody (Legal documentation required if not joint custody)

Parent/Guardian Street Address (if different from above)	City	State	Zip

Parent/Guardian Home Phone #	Mother's Cell Phone #	Father's Cell Phone #	E-mail Address

Next of Kin/Emergency Contact Name	Relationship	Telephone #

PRIMARY INSURANCE COMPANY – EFFECTIVE DATE _____

Name of Insurance Company	Policy ID #	Group #

Claims Address	City	State	Zip	Telephone #

Name of Policy Holder	Date of Birth	Relationship to Insured	If Behavioral benefits are Separate list as Secondary (see back of insurance card)

Employer Name and Address

SECONDARY INSURANCE COMPANY – EFFECTIVE DATE _____

Name of Insurance Company	Policy ID #	Group #

Claims Address	City	State	Zip	Telephone #

Name of Policy Holder	Date of Birth	Relationship to Insured	

Employer Name and Address

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I request that payment of authorized insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Signature _____ Date _____

Child and Adolescent Health Specialists, PC

PATIENT HISTORY FORM

Child's Name: _____ DOB: _____

Your Name: _____ Relation to child: _____

Child lives with: _____ Relation to Child: _____ DOB:_____

Siblings:_____ Age:____ Siblings: _____Age:_____

Siblings:_____ Age:____ Siblings:_____ Age: ____

Referred by: _____

Current or Previous Diagnoses/Disabilities/Medical Concerns: _____

_____

Child's Primary Care Physician:_____

Address: _____

Telephone: _____

Current Medication(s): _____ Dose _____

_____ Dose _____

_____ Dose_____

Treating Physician:_____

Name of School / Daycare: _____

Address:_____

Grade:_____

Developmental issues: _____

Learning style issues: _____

Is your child currently on an IEP or 504 plan? Yes No

Date of last CORE evaluation: _____

How would you rate your child's school performance at this time?

____ Good ____ Fair ____ Poor

Child and Adolescent Health Specialists, PC

Mental Health History:

What are the issues you are concerned with today?:_____

_____

_____

_____

Past treatment:_____

_____

_____

Self-Harm/ Suicidality/ homicidal thoughts: _____

_____

_____

Hospitalizations: _____

_____

_____

Family History:

Family Mental Health history:_____

_____

_____

Substance Use/Abuse/ Dependence:_____

_____

_____

Trauma History: _____

_____

_____

Self-Harm/ Suicidality/ homicidal thoughts: _____

_____

_____

Medical Concerns: _____

_____

Legal History: _____

DCF: _____

DYS/Probation/Parole: _____

Other Agencies/Services: _____

Child and Adolescent Health Specialists Counseling Payment Agreement

- Fee Structure-
  - $150 per one on one session (individual, parents only or family)
  - $30 per Telephone consultation/Collateral Contact/Case management (over 10 minutes)(not covered by insurance). Care management services may be covered by insurance, copay/deductible may apply.
  - Payment is expected at time of appointment/service by cash, check or credit card
  - If an economic hardship develops, a reduced fee or other accommodations may be available. Please present 1040 tax form. Federal guidelines will be followed.
  - Other non- covered services are payable on date of service

- Insurances accepted to which we will submit claims: Blue Cross and Blue Shield (See back of insurance card for Mental Health Benefits), United Behavioral Health (for Harvard Pilgrim/ United Healthcare), Tufts, Cigna and Tricare. If you have a deductible or out of network benefits, patient portion is payment is due at the time of appointment. Self-pay is due at time of appointment.
  - Client is responsible for co-payment at the time of the appointment.
  - By law, our Practice cannot waive or reduce insurance fees or co-payments.

- Late Cancellation/Broken appointment policy-
  - 48 hours' notice during business hours, (Friday for Monday appointments), is required to cancel or reschedule an appointment.
  - Late Cancellations/No show will be charged to your credit card below if less than 48 hours' notice is given.

- Late Arrival Policy-
  - For each 15 minutes that a patient is late, you will be charged $50, due on that date of service. If you are over 30 minutes late, you will be charged $150 and the appointment will be rescheduled.

Exceptions to above policies may be made in the instance of a documented serious medical issue or serious immediate family emergency.

- Balances due- Balances including late/no show fees will be charged to your credit card on file.
  - Outstanding balances must be paid prior to the next appointment.
  - Appointments cannot be scheduled if balances have not been addressed.

Agreement: I understand that I am responsible for payment in full of all charges and agree to provide a current credit card to be billed for my balances. By signing below, I agree to the above-described payment agreement, and

A) If billing to insurance: I request that payment of authorized insurance benefits be paid directly to Child and Adolescent Health Specialists, PC. I also authorize Child and Adolescent Health Specialists, PC to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

B) If paying privately: I agree to pay the fee of $150 at the time of service.

_____ Date _____

Parent/Legal Guardian Signature

Type: (circle one) MasterCard or Visa. Name on Card: _____

Credit Card #: _____ Expiration Date: _____ CVV # : _____

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HIPAA PRIVACY PRACTICES

This is a summary of how we use and disclose your Protected Health Information. Please read the full Notice of Privacy Practices available on our web site or at our front desk or request a copy to be mailed to you, prior to signing this form.

A. We have a legal duty to protect health information about you.

B. We may use and disclose Protected Health Information or "PHI" about you in the following circumstances: ***see full Notice of Privacy Practices for examples***

1. We may use and disclose PHI about you to provide health care treatment to you.
2. We may use and disclose PHI about you to obtain payment for services.
3. We may use and disclose your PHI for health care operations.
4. We may use and disclose PHI under other circumstances without your authorization, such as when required by law or for public health activities.
5. You can object to certain uses and disclosures.
6. We may contact you to provide appointment reminders by voice message, text or email.
7. We may contact you with information about treatment, services, products or health care providers.
8. We may contact you for fundraising activities.

Any other use or disclosure of PHI about you requires your written authorization.

C. You have several rights regarding PHI about you.

1. You have the right to request restrictions on uses and disclosures of PHI about you.
2. You have the right to request different ways to communicate with you.
3. You have the right to see and copy PHI about you.
4. You have the right to request amendment of PHI about you.
5. You have the right to a listing of disclosures we have made.
6. You have a right to a copy of this notice.

D. You may file a complaint about our privacy practices.

E. A copy of the full description of Child and Adolescent Health Specialists, PC privacy practices has been made available to me. I understand my rights and how my protected health information can be used by Child and Adolescent Health Specialists, PC.

F. For additional information regarding privacy practices, contact the Office Manager.

This Notice of Privacy Practices is effective as of today's date: _____

Patient's Name: _____

Parent/Guardian Signature: _____