Katie Danielle Wade, MSN, APRN, PMHNP-BC
7161 Lee Highway, Suite 400
Chattanooga, Tennessee 37421
Office: 423-708-8670
Fax: 423-708-8671

CHILD & ADOLESCENT INFORMATION FORM

This Form is Confidential

Identifying Information

Today's date: _____
Your child's name:

_____
Last First Middle Initial

Child's date of birth: _____ **Age:**_____ **Child's Social Security #**_____

Child's Address:_____
_____

Telephone number: _____
Can we leave a message at this number? YES or NO
Gender and Sexual Identity:
__ Male __ Female __Transgender __Other _____
__Heterosexual __Lesbian __Gay __Bisexual __Asexual __In Question
__Other _____
Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

Referred by: _____ telephone number:_____
Your signature indicates that we can communicate with the referral source as needed:

(Parent/Guardian Signature):_____

Child'sPCP:_____Office number _____
Your signature indicates that we can communicate with the PCP as needed:

(Parent/Guardian Signature):_____

Person(s) to notify in case of any emergency:

_____ _____
Name Phone

_____ _____
Name Phone

We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so:
(Parent/Guardian Signature):_____

Pharmacy Info:

Pharmacy Name:_____ **Pharmacy Address:**_____
Pharmacy Phone:_____**Pharmacy Fax:**_____

Parent's Name:

_____
Last First Middle Initial

Parent's Date of Birth: _____ **Parent's Social Security #:** _____
Parent's Address: Same as child's YES or NO, if NO please list

_____
City: _____**State:** _____ **Zip:**_____

Parent's Name of Employer: _____
Address of Employer: _____
City: _____**State:** _____ **Zip:**_____
Home Phone: _____**Work Phone:** _____
Cell Phone: _____ **Email:** _____

Parent's Name:

_____
Last First Middle Initial

Parent's Date of Birth: _____ **Parent's Social Security #:** _____
Parent's Address: same as child's YES or NO, if NO please list

_____
City: _____**State:** _____ **Zip:**_____
Parent's Name of Employer: _____
Address of Employer: _____
City: _____**State:** _____ **Zip:**_____
Home Phone: _____**Work Phone:** _____
Cell Phone: _____ **Email:** _____

PRIMARY INSURANCE INFORMATION:

Name of Insured Person:

_____
Last First Middle Initial

Insured's relationship to patient_____ **Insured's DOB:**_____
Insurance Company: _____ **Insurance ID number** _____
Insurance Group number _____ **Insured's SSN:**_____

Secondary Insurance

Name of Insured Person:

_____
Last First Middle Initial

Insured's relationship to patient_____ **Insured'sDOB:**_____
Insurance Company: _____ **Insurance ID number** _____
Insurance Group number _____ **Insured's SSN:**_____

Please briefly describe your child's presenting concern(s):

_____

_____

_____

PAST MEDICAL HISTORY:

Height _____ Weight (if applicable) _____

Previous medical hospitalizations (Approximate dates and reasons):

Hospital	Date:	Reason:

Place an X by past surgical procedures (Approximate dates and reasons):

Procedure:	Date:	Procedure:	Date:
___Anesthetic Complications		___Heart Surgery	
____Appendectomy ____Breast Surgery		___Hemorrhoidectomy	
___Bowel Resection ___Bladder Repair		___Hernia Repair	
___Cancer removal		___Kidney Removal ___Knee surgery	
___Carpal Tunnel		___PE Tubes ___Splenectomy	
___Cesarean Delivery ___Dialysis		___Thyroidectomy	
___Gall Bladder Removal		___Tonsillectomy ___Wisdom Teeth Ext.	
___Other		___Other	

Are you allergic to any medications? If yes, please list what reaction:

Medication/Food Allergy	Date (age)	Reaction

Place an X by any significant medical problems, symptoms, or illnesses:

___Anemia ___Arthritis/Joint Dz	___Gastritis ___GERD	___Seizures ___Skin Disorders
___Asthma ___Bleeding Disorder	___Heart Attack ___Hepatitis B	___Sleep Apnea ___Stomach Ulcers
___Bladder Issues ___Bowel Issues	___Hepatitis C ___HIV	___Stroke ___Thyroid Disease
___Bronchitis ___Cancer	___Insomnia ___Kidney Disease	___UC/Crohns DZ
___Diabetes Type I ___Diabetes Type II	___Liver Disease ___Narcolepsy	___Other
___DVT/Blood Clot ___ Female Issues	___Pain (Chronic_ ___Polycystic Ovaries	

Current Medications: (NON PSYCHIATRIC)

Medication:	Dose:	Purpose:	Prescriber:

DEVELOPMENT HISTORY:

Birth weight_____Type of Delivery_____Complications_____
Age of walking_____Age of talking_____Age of potty training_____

PAST PSYCHIATRIC HISTORY:

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____
_____
_____

Have you ever thought about committing suicide? Please describe:
_____
_____

Have you ever tried to commit suicide? Please describe:

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):

Hospital:	Date:	Reason:	Treatment:

Place an X by any significant psychiatric problems for which you have been treated:

___ADHD inattentive	___Autism	___Depression	___Panic Disorder without Agoraphobia
___ADHD hyperactive	___Bipolar Type I Depression	___Generalized Anxiety	___Psychosis
___ADHD mixed type	___Bipolar Type I Mania	___Impulse Control d/o	___PTSD
___Adjustment Disorder	___Bipolar Type I Mixed	___Kleptomania	___Schizoaffective
___Alcoholism	___Bipolar Type II	___OCD	___Schizophrenia
___Asperger's	___Borderline Personality	___Panic Disorder with agoraphobia	___Substance abuse
___Other			___Trichotillomania

Current Psychiatric Medications:

Medication:	Dose:	Reaction or Reason Discontinued:	Prescriber:

Previous Psychiatric Medications:

Medication:	Dose:	How long:	Prescriber:

SOCIAL HISTORY:

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

To your knowledge has your child ever drank alcohol? if yes please list

_____

_____

To your knowledge has your child every used drugs? If yes please list

_____

_____

_____

LEGAL:

Has your child ever been arrested? If yes please list

_____

_____

Is your child on probation or ever been on probation? If yes please list

_____

_____

SOCIAL FAMILY HISTORY:

How would you describe your child's relationship with his or her mother:

_____

_____

How would you describe your child's relationship with his or her father?

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her?

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life:

How many sisters does your child have?_____ Ages?_____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?__

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationships with his/her peers?

Please briefly describe any history of abuse, neglect and/or trauma:

Please briefly describe your child's self-care and coping skills:

What are your child's diet, weight, and exercise/activity patterns?

Child's current school attend school? _____Current grade?_____

Does your child have an IEP or 504 plan? If yes, please list:

Please briefly describe your child's school performance and experience:

What are your child's hobbies, talents, and strengths?

Any additional information you would like to include:

_____

_____

Please place an "x" in the now or past box if the problem listed applies to the child:

Problems with	Now	Past	Problems with	Now	Past
Anxiety			Makes careless mistakes		
Depression			Fidgets frequently		
Anger/Temper			Impulsive		
Panic			Waiting their turn		
Fears			Completing tasks		
Irritability			Easily distracted		
Concentration			Hyperactivity		
Worries			Alcohol abuse		
Talking with others			Drug use		
Separation anxiety			Problems falling asleep		
Tantrums			Problems staying asleep		
Parents Divorced			Unexplained weight loss		
Cries easily			Unexplained weight gain		
Problems with friends			Frequent upset stomach		
Problems in school			Frequent headaches		
Fear of strangers			Diarrhea		
Afraid of the dark			Excess sweating		
Sexually acting out			Shortness of breath		
History of child abuse			Dizziness		
History of sexual abuse			Fainting		
Thoughts of hurting others			Nausea		
Thoughts of hurting self			Constipation		
Nightmares			Chest pain		

FAMILY HISTORY: Please mark an "X" in the box that applies to family members.

Disorder	mother	father	maternal grandma	maternal grandpa	paternal grandma	paternal grandpa	uncle	aunt	sister	brother
Adhd										
Anxiety										
Aspergers										
Autism										
Bipolar										
Depression										
Psychiatric Hospitalization										
OCD										
Panic Attacks										
PTSD										
Schizophrenia										
Substance Abuse										
Suicide attempt										
Suicide Completion										

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Authorization For Treatment, Payment and Healthcare Operations:

I authorize Danielle Wade, to release to my insurance company, managed care organization, state agency, Health Care Financing Administration, Third Party Administration any information needed to process my claims and or determine benefits payable for related services.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges at the time of service. I understand that unless otherwise restricted by a contractual agreement with selected insurance plans/third party payers, the entirety of the charges incurred will be transferred to the the guarantor's responsibility if the payment is not received from the insurance company within 60 days. I understand that I will be bound by any conditions of this agreement regarding guarantor/patient responsibility charges. I understand that failure to meet my financial responsibility in a timely manner may result in my account being turned over to a collections agency. I understand that payment is due at the scheduled appointment.

There is a $30 fee for all returned checks. If two returned checks are received, Danielle Wade reserves the right to request future payments be made in cash or credit card.

I give consent for evaluation and treatment by Danielle Wade.

I have read, understand and agree to the above policies.

_____
Print Patient/Guarantor Name

_____ _____
Patient/Guarantor Signature (must be at least 18 years old) Date

_____ _____
Witness Signature Date

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Missed Appointment and Late Cancellation Policy

Danielle Wade whenever possible, will call you to remind you of your appointment but, you are responsible for attending your scheduled appointment. A $50 fee will be added to the patient's account if a patient does not attend their appointment or if they cancel their appointment within 24 hours of the scheduled appointment time. This fee is not covered by insurance and must be paid at the next appointment.

***Please initial if you would or would not like to receive notification about your appointment.**

_____ Yes, I want Danielle Wade to text me at this number to remind me of a scheduled appointment. Telephone number _____. An email is required to set up text reminder services. Email: _____

_____ No, I DO NOT want Danielle Wadeto attempt to contact me to remind me of my scheduled appointment time.

After Hour Calls Policy

Calls made to the provider after hours are subject to a $25 fee due at the next scheduled appointment.

Paperwork Policy

There is a $35 fee for any paperwork (FMLA paperwork, Disability forms, Letters, School forms etc.) completed by a provider.

Medication Refill Policy

Danielle Wade requires a **72 hour** notice for medication refill request to be processed. When requesting a refill patient/guardian must provide the following information: name of medication, dose, when medication is taken, pharmacy name and telephone number. Request for refills may be left on the refill line, please keep in mind calls received after 3pm daily will not be returned until the next business day.

I have read, understand and agree to the policies listed above.

_____
Print Patient/Guarantor Name

_____ _____
Patient/Guarantor Signature (must be at least 18 years old) Date

_____ _____
Staff Signature Date

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CONSENT FOR RELEASE OF MEDICAL INFORMATION:

I, _____ grant permission for the person(s) listed below to have access and all of my information that pertains to my care from the physicians or providers of this group. This includes but is not limited to, appointment time, lab results, my physician's plans for health care, etc.
I agree to notify in writing, if there are any changes in the person(s) authorized.

Patient Name: _____ DOB_____/_____/_____

Signature (patient or legal guardian): _____

Date: _____/_____/_____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

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Acknowledgement of Receipt of Patient Notification of Privacy Practices

I, _____ have been presented with a copy of Katie Danielle Wade, MSN, APRN,PMHNP-BC, Patient Notification of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law and I understand the contents of the Notification. By law, Katie Danielle Wade, MSN, APRN, PMHNP-BC, is required to obtain your signature indicating that you have received this document. Your signature below does not surrender any rights or confidentiality. Any updates to this policy will be posted on our website or in our waiting room for your review.

_____ _____
Patient Name DOB

_____ _____
Print Patient/Guarantor Name Date

_____ _____
Patient/Guarantor Signature (must be at least 18 years old) Date

For Internal Use
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date the notice was presented to the patient and sign below.

Presented on (date) _____

By: (name and title) _____

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Debit/Credit Card Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.
6. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. I will not be provided with advance notice of payments authorized hereunder for transactions up to an amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

_____ _____
Name as it appears on Card/ACH Account Email Address

_____
Billing Address City State Zip

_____/_____/_____
Phone Number

AUTHORIZED SIGNATURE_____ DATE_____/_____/_____