the Coastal Center

Last Name:_____

Patient Information – Please Complete All Pages

Child's Name:_____ DOB:_____/_____/_____

Age:_____ Grade:_____ School:_____

Home Address:_____

Parent and Family Information

Name:_____

___ Mother ___ Father ___Guardian:_____

Home Phone:_____ Cell:_____ Work:_____

Email:_____

Name:_____

___ Mother ___ Father ___Guardian:_____

Home Phone:_____ Cell:_____ Work:_____

Email:_____

Marital Status of Parents:

___ Married ___ Divorced ___ Separated ___ Remarried

___ Domestic Partnership ___ Single ___Widow(er)

the Coastal Center

Last Name:_____

Custody Arrangement (if applicable):_____

_____

Is your child adopted? ___ Yes ___ No If yes, at what age? _____

Been informed? ___ Yes ___ No

Name(s) and age(s) of sibling(s):_____

_____

Name(s) of other(s) living in the home:_____

_____

Medical History

Significant medical history relating to birth, infancy and childhood:_____

_____

_____

_____

Diagnosis (medical/mental health):_____

_____

Current Medications (name/dose/frequency):_____

_____

Previous Medications:_____

the Coastal Center

Last Name:_____

Education and Social Information

Name of school child currently attends: _____

Dismissal Time:_____

Previously attended school(s):_____

_____

Academically, your child is doing:

___ Excellent ___ Very Well ___ Well ___ Fair ___Poor

Does your child have learning disabilities? ___ Yes ___ No

If yes, what type?_____

_____

Does your child receive special education services (IEP/504)? __ Yes __ No

If yes, please describe:_____

_____

Socially, your child is doing:

___ Excellent ___ Very Well ___ Well ___ Fair ___Poor

List the area(s) where your child experiences the greatest success:

_____

_____

_____

the Coastal Center

Last Name:_____

List the area(s) where your child experiences the greatest difficulties:

_____

_____

_____

What is your child's ability to respond to social cues?

_____

_____

_____

What type of child does your child enjoy playing with? What do they do?

_____

_____

_____

Describe your child's frustration tolerance? What situations lead to frustration? What helps your child to regain control/calm down?

_____

_____

_____

How does he/she manage transitions?

_____

_____

the Coastal Center

Last Name:_____

Does your child follow rules? What occurs when he/she does not comply?

_____

_____

_____

Describe your relationship with your child:

_____

_____

_____

What are the areas that you would like us to focus on when working with your child?

1. _____

   _____

2. _____

   _____

3. _____

   _____

This form was completed by:

_____ Date:_____

the Coastal Center

Last Name:_____

Client Agreement

Confidentiality

Everything that you discuss with our staff at The Coastal Center will be kept confidential. Exceptions include, but are not limited to, situations that 1) you are in danger of harming yourself or someone else, 2) you report abuse or neglect of a child, elder or disabled person in your care, 3) if we are asked to appear in court on your behalf or on behalf of another party, or if your records are subpoenaed for legal purposes, 4) if you give us written permission to share information with a family member, another therapist or a physician on your behalf. We utilize consultations when needed.

Scheduling and Fees

Sessions for families will be scheduled for 50-60 minutes and individual sessions will be 40-50 minutes. If you are unable to arrive on time, we will end at the scheduled time. Twenty-four-hour notice of cancellation is expected to avoid a charge for your scheduled session. Insurance companies cannot be billed for cancellations.

Initial evaluation: $125 per intake
Individual and Family Therapy: $120 per session
Documentation Fees for letters and reports: $80 per hour
Other Services Including Phone Calls, Letters, Reports and Collateral Work: $80 per hour

Insurance Benefits

If we have a contract with your health insurance provider, we will bill them and accept payment according to that contract. If we do not have an agreement with your insurer, you must pay at the time of your visit and seek reimbursement from your insurer. We will help you to keep track of how many sessions you have used. In all cases you are ultimately responsible for knowing this information and paying for services. Please bring your insurance card to your first appointment so we can make a copy of it.

Name of Subscriber:_____ DOB:_____
Address (if different):_____

Insurance Company: _____

Emergency Coverage

Although we do our best to respond promptly, we are not always immediately available in emergencies. In such an instance, it is your responsibility to seek appropriate attention at a local emergency room.

Agreement

I have read the above and agree to participate in treatment with these policies.

Signature:_____ Date:_____

the Coastal Center

Last Name:_____

HIPPA Authorization for Use or Disclosure of Health Information

Patient Name:_____ DOB:_____/_____/_____

Cell Phone:_____ Home Phone:_____

I authorize the Coastal Center to leave messages with medical information on:

___ My cell phone ___ My home phone (check one or both)

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office. My revocation will be effective once received by (The Coastal Center for Developing Minds).
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
3. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

Patient or Guardian Signature:_____ Date:_____

Name:_____ Relationship:_____