DR ☐ JA ☐ KA ☐ HA ☐ RG ☐ EL

INS

☐ MCD	☐ MHCA	☐ ALLKIDS
☐ BCBS	☐ ABBM	☐ SELF PAY
☐ UBH	☐ TRICAR	☐ OTHER:

Ackerson & Associates

PATIENT REGISTRATION FORM

Patient Name:	DOB:	Age: ☐ Male ☐ Female
Parent's Name:	Legal Guardian: ☐ Yes ☐ No	
Address:		
City:	State:	Zip Code:
County:	Email:	
Home phone: Work phone: Cell phone: Preferred phone number to contact you for appointment reminders: ☐ Home ☐ Work ☐ Cell		
Referred by:		
Presenting Complaint/Comments: If injury is a reason for referral, please note the date:		

Responsible Party

Name:	Date of Birth:	SS#:
Address:		
City:	State:	Zip Code:
Employer:	Home phone: Cell phone:	Work phone:

Insurance Information (Primary)

Company:	Subscriber Name:
Contract or Member Number:	Group Number:
Subscriber DOB:	Subscriber SSN:
Subscriber relationship to patient: (circle)	Parent Guardian Spouse Self

Insurance Information (Secondary)

Company:	Subscriber's Name:
Contract or Member Number:	ID & Group Number:
Subscriber DOB:	Subscriber SSN:
Subscriber relationship to patient: (circle)	Parent __Guardian ___Spouse___ Self ___

PATIENT INFORMATION

Child/Patient Name | Date of Birth | Patient age | Sex: ☐ Male ☐ Female

Name of person completing this form | Relationship to patient

Name(s) of legal guardian(s), if different | telephone # | Relationship to patient

Name of person/Doctor who referred you for treatment

PRESENTING CONCERNS

Patient's Problems as You See Them (please do not leave blank)	**When did Problem Begin**
Example: *My child is aggressive and gets into fights about weekly at school. He has been suspended 4 times for fighting at school this year.*	*Two years ago*
1.	
2.	
3.	
4.	

FAMILY INFORMATION

Please list **ALL** individuals living in the child's household:

Name	Age	Relationship	Education Level	Occupation
Example: *Jane Dow*	*52*	*Grandmother*	*Some college*	*homemaker*

Please list all OTHER family/caregivers **NOT** currently residing with the patient (this would include biological parents, step parents, siblings, step siblings, etc.)

Name	Age	Relationship	Education Level	Occupation
Example: *Ashley Smith*	*30*	*Biological Mother*	*Finished HS*	*sales*

Marital Status of biological parents, parents or legal guardians:

□ Married/ Remarried □ Divorced □ Living Together
□ Single/Never Married □ Legally Separated □ Widow

If parents are separated or divorced, how old was patient at time of separation? _____

In the past year, has your child: □ moved □ started a new school
□ experienced the death of a family member/close friend
□ other (please describe): _____

Please describe any information regarding family that may contribute to stress for the child including visitations, step parents, foster care, adoption, or other custody issues: _____
_____
_____

Has the Department of Human Resources (DHR) ever been involved with the child? □ No □Yes
If yes, please list any situation requiring DHR, Family Court, or Juvenile Probation involvement: Social worker / Case worker: _____Phone #: _____
Dates of involvement: _____ Reason for involvement: _____
_____

BIRTH/DEVELOPMENTAL HISTORY

Is the child adopted? □ Yes □ No If the child was adopted, child's age at adoption____
If not a biological child of parent, is the child aware of this? □ Yes □ No

Check the corresponding box if the biological mother used the following during pregnancy:
□ Alcohol □ Cigarettes
□ Over-the-counter medications □ Antibiotics
□ Prescription Medicines
□ Recreational/Street drugs (Examples: cocaine, marijuana, amphetamines, heroin etc.)
□ Other_____

Please list any problems experienced by the mother during pregnancy: (Examples: high blood pressure, Diabetes, bed rest ordered etc. _____
_____

Were there any complications at birth (Examples: Use of forceps, cesarean birth, vacuum/suction, etc…)?
□ No □ Yes If yes, please specify:_____

Was the baby premature? □ No □ Yes If yes, how early was the baby? _____
Birth weight: Pounds ____ Ounces_____

Type of Nursery (answer all that apply): □ Well baby □ Intensive care Length of stay in nursery:_____days
Please describe any difficulties _____
_____

If child experienced significant birth complications please request birth records from hospital and attach to this form.

What was your child's personality from birth to 1 year:
□ easy going □ slow to warm up to others □ demanding and difficult to please
Other _____

Age at which your child could do the following (If specific ages unknown please indicate early, late, or on-time.)

Smile ____	□ early □ late □ on time	**Crawl _____**	□ early □ late □ on time
Coo/babble ____	□ early □ late □ on time	**Stand alone _____**	□ early □ late □ on time
Roll over ____	□ early □ late □ on time	**Walk alone _____**	□ early □ late □ on time
Sit alone _____	□ early □ late □ on time	**Feed self _____**	□ early □ late □ on time
Single words _____	□ early □ late □ on time	**Dresses self _____**	□ early □ late □ on time
Phrases _____	□ early □ Late □ on time	**Short sentences _____**	□ early □ late □ on time

Toilet trained: Bowel _____ □ early □ Late □ on time
Bladder_____ □ early □ late □ on time

How much of your child's speech is understandable to you? □ some □ most □ all
How much of your child's speech is understandable to others? □ some □ most □ all

Hand preference: □ right □ left □ both □ not sure
When was hand preference established? _____

Does your child have any problems with:

Coloring	□ No	□ Yes	Handwriting	□ No	□ Yes
Dressing him/herself	□ No	□ Yes	Walking	□ No	□ Yes
Running	□ No	□ Yes	Playing sports	□ No	□ Yes
Riding a bike	□ No	□ Yes	Cleaning him/herself	□ No	□ Yes

What does your child enjoy doing in his/her spare time? _____

_____

MEDICAL HISTORY

If your child has a significant medical history (for example- concussion or other brain injury, epilepsy, or any other neurological events or disorders) please include, or ask your referring physician or agency to send us, copies of discharge notes (if hospitalized), the most recent doctor outpatient visit notes, and reports from any EEG or neuroimaging studies.

Childhood Illnesses Other Than Colds: □ No □ Yes

Type **How often** **Approximate Date**

_____

_____

_____

Surgeries: □ No □ Yes

Date Type Hospital name and location Reason

_____

_____

_____

Other hospitalizations: □ No □ Yes

Date Hospital name and location Reason

_____ _____ _____

_____ _____ _____

_____ _____ _____

Accidents Or Injuries: □ No □ Yes

Date Type

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications (please bring all medications to the evaluation):

Type of medication **Dose** **Reason**

_____

_____

_____

_____

_____

Does your child have any of the following problems?

Allergies	□ No	□ Yes	**If Yes, explain**_____
Seizures	□ No	□ Yes	**If Yes, explain**_____
Sleep problems	□ No	□ Yes	**If Yes, explain**_____
Vision problems	□ No	□ Yes	**If Yes, explain**_____
Hearing problems	□ No	□ Yes	**If Yes, explain**_____
Eating problems	□ No	□ Yes	**If Yes, explain**_____

Current weight_____Current height_____

MENTAL HEALTH HISTORY

Has your child ever taken psychiatric medication? □ No □ Yes
(i.e., depression, ADHD, etc.). If yes, please name_____

Has your child ever been diagnosed with a mental health problem (e.g., ADHD, depression, anxiety, etc.)?
□ No □ Yes If yes, please describe_____

Has your child ever completed and evaluation with a psychologist or other mental health professional?
□ No □ Yes □ Don't know
Please bring copies of all evaluations that have been completed, if available, to the appointment

Has your child ever received mental health related therapy? □ No □ Yes □ Don't know
If yes, how would you describe the effectiveness of this treatment?
□ Much improvement □ Some improvement □ No improvement

Comments: _____

FAMILY PSYCHIATRIC HISTORY

Is there a history on either side of the child's family of any of the following conditions?

Condition	**Father's Side**	**Mother's Side**	**Relationship to child (Parent, grandparents, aunt, etc.)**
Attention Deficits	□ No □ Yes	□ No □ Yes	_____
Hyperactivity	□ No □ Yes	□ No □ Yes	_____
Learning problems	□ No □ Yes	□ No □ Yes	_____
Autism	□ No □ Yes	□ No □ Yes	_____
Mental retardation	□ No □ Yes	□ No □ Yes	_____
Speech or language problems	□ No □ Yes	□ No □ Yes	_____
Depression	□ No □ Yes	□ No □ Yes	_____
Bipolar Disorder	□ No □ Yes	□ No □ Yes	_____
Anxiety	□ No □ Yes	□ No □ Yes	_____
Personality Disorder	□ No □ Yes	□ No □ Yes	_____
Schizophrenia	□ No □ Yes	□ No □ Yes	_____
Severe mental illness	□ No □ Yes	□ No □ Yes	_____
Epilepsy (seizures)	□ No □ Yes	□ No □ Yes	_____
Birth defect	□ No □ Yes	□ No □ Yes	_____
Multiple Sclerosis	□ No □ Yes	□ No □ Yes	_____
Alcohol/drug problems	□ No □ Yes	□ No □ Yes	_____
Tics or other movements	□ No □ Yes	□ No □ Yes	_____
Genetic Disorders	□ No □ Yes	□ No □ Yes	_____
Other, specify	_____		

Outside of biological relatives, are there **any other people with whom the child has significant contact** who have psychiatric problems? □ No □ Yes □ Don't know
If yes, please specify the contact(s) and describe the problem(s), including treatment: _____

_____

_____

EMOTIONAL/BEHAVIORAL FUNCTIONING

Do you have concerns about your child's mood or anxiety (worries)? □ No □ Yes

If so, what concerns you? _____

_____

Does your child exhibit any of the following in your home?

□ Difficulty completing a task	□ Excessive activity	□ Disorganization
□ Difficulty following directions	□ Day dreams	□ Deliberately annoying others
□ Refusing to comply with requests	□ Tantrums	□ Defiance
□ Frequent arguments with family members	□ Destroying property	□ Aggressiveness
□ Odd habits or interests	□ Repetitive Behaviors	□ Confused thinking/beliefs
□ Depressed mood	□ Low self-esteem	□ Withdrawn from others
□ Cries easily	□ Mood swings	□ Shy
□ Excessive worrying	□ Nervous habits	□ Unusual worries or fears
□ Difficulty getting along with others	□ Repetitive behaviors	□ Poor eye contact
□ Peer relationship problems	□ Difficulties communicating	

To your knowledge, does your child engage in risk taking behaviors such as use of tobacco, drugs and/or alcohol? □ No□ Yes If yes, what substances does your child use? _____

How often? _____

□ Other behavioral problems (please specify)

_____

_____

EDUCATIONAL HISTORY

Name of current school:_____ Grade:_____

Teachers:_____

Current Placement: □ Regular □ Alternative school □ Special education :
□ for behavior only □ for learning difficulties □ Both □ Other:_____

How many schools has your child attended this school year? □ One (current) □ 2-3 □ 3 or more

Any prolonged absences from school? □ No □ Yes When_____ How long_____

Has your child repeated any grades? □ No □ Yes Which one(s)_____

Has your child been suspended **this school year**? □ No □ Yes How many times?_____ Please list reason for suspension:_____

Has your child been tested for special education placement by the school? □ No □ Yes When?_____

Does your child have an Individualized Education Plan (IEP), 504 Plan, or Other Health Impaired (OHI) services at school? □ No □ Yes

Does your child receive the following special services (check all that apply)?

Physical therapy	_____	Vision impaired	_____
Occupational therapy	_____	Adaptive P.E.	_____
Speech/language therapy	_____	Hearing impaired	_____

****Please bring copies of school records of testing and educational plans (IEPs), if available**.

Specific educational difficulties: □ Spelling □ Math □ Reading □ All Subjects
□ Speech/Language □ Occupational Therapy □ Other: _____

Current Academic Performance: □ A's □ B's □ C's □ D's □ F's

Past Academic Performance: □ A's □ B's □ C's □ D's □ F's

Peer relationships: □ Aggressive/Fights a lot □ Very Friendly
□ Has no friends □ Teased/Bullied by others

Work History if applicable (attendance, relationship with boss):_____

_____

Which of the following problems, if any, does this child have in school?

□ Does not do homework	□ Starts but does not finish homework	□ Poor math
□ Fails to check homework	□ Poor handwriting	□ Poor Spelling
□ Poor reading skills	□ Forgets assignments	□ Messy and disorganized
□ Does not remain seated	□ Incomplete classroom work	□ Poor reading comprehension
□ Poor attention in class	□ Disobeys in class	□ Talks out excessively in class
□ Distracted	□ Test Anxiety	□ Makes many careless errors
□ Gets bullied	□ Bullies others	□ Difficulty separating from parents
□ Excessive time to complete assignments		□ Problems with written language

Further comments on homework, academic functions, and peer relations: _____

_____

_____

Patient Financial Responsibility Statement

Please understand that financial responsibility for neuropsychological or psychological services rests between the insured and the health plan. While we are pleased to be of service by filing your insurance, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as patient/insured to pay the denied amounts in full. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.
IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT EACH VISIT:

* If you are not insured, or if the services being provided are not covered by your insurance, payment in full for services is expected at the time they are rendered.

* If you have insurance, any co-payment and applicable deductible amounts required by your insurance must be paid at the time of service unless other arrangements have been made with our office.

- If you do not know your co-pay we will collect a minimum fee of $30.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion. If you are not prepared or unable to pay your co-payment prior to your visit, we will kindly reschedule your appointment for a more convenient time.
- Overpayments will be refunded after all charges have been processed and paid by your insurance company **and your treatment provider has indicated all services have been provided**. A refund check will be written and mailed within approximately 30 days after billing department is notified of completion of services.

* The remainder of your bill will be sent to your health plan for direct payment to our office.

* In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. The insured is responsible for required copayments, applicable deductible amounts and any services that are not covered by your insurance plan.

* If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.

* Your health plan may refuse partial payment or entire payment of a claim for some of the following reasons:
1) This is a pre-existing condition or a condition not covered by your plan
2) You have not met your full calendar year deductible or a copayment is due
3) The type of medical service required is not covered by your plan
4) The health plan was not in effect at the time of service
5) You have other insurance which must be filed

APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED TO YOU (NOT THE INSURANCE COMPANY) AT THE REGULAR RATE. WE DO TRY TO COMPLETE REMINDER CALLS AS A COURTESY. HOWEVER, IF THE REMINDER SYSTEM DOES NOT WORK IT IS STILL THE PATIENT'S RESPONSIBILITY TO MAKE THEIR APPOINTMENTS OR CANCEL THEM ON A TIMELY BASIS:_____(please initial)

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier. My signature authorizes payment of medical benefits by the insurance company(ies) to the psychologist providing services and authorizes release of any necessary medical records to process the insurance claim. If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and costs of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of potions of the patient's record.

_____ _____

Signature of Responsible Party Responsible Party – Printed

_____

Date:

My signature below acknowledges:

- Accuracy of above information and financial responsibility to pay any balance and fees for attorney if required for account collection. I also understand that evaluation findings and subsequent report may not be sent if there is a remaining balance on the account.
- Understanding that if my attorney, the school system, or other agency is paying for an evaluation that they have the right to receive all the information generated by the evaluation and the usual rules of confidentiality may not apply.
- Notice of HIPAA and State of Alabama policy and practices to protect your health information

Signed: _____Date:_____
(Note: Adult patients and Parent/Guardian of patients under 18 must sign)

Witness:

_____ Date: _____

and Authorizes:

- Consent to be evaluated and/or treated by your provider at Ackerson & Associates.
- Your provider at Ackerson & Associates to release any and all information required to process my insurance claim and for insurance benefits to be paid to your provider of services.
- Consent to release treatment information to Ackerson & Associates providers only in the event of an interoffice referral
- Consent to release requested information to the referring physician/source

At all times, I retain the right to revoke this Authorization. Such revocation must be dated and submitted to my provider at Ackerson and Associates in writing. The revocation shall be effective *except* to the extent that the psychologist or staff at Ackerson and Associates has already used or disclosed information in reliance on this Authorization.

Signed: _____Date:_____
(Note: All patients 14 years and older must sign.)

Witness: _____Date: _____