MSU Health Care

# MICHIGAN STATE UNIVERSITY
# DEPARTMENT OF PSYCHIATRY

## PSYCHIATRIC ASSESSMENT SERVICES FOR CHILDREN AND ADOLESCENTS

Thank you for your interest in *Michigan State University's Psychiatric Assessment Services for Children and Adolescents*, a service of the Department of Psychiatry and the MSU HealthCare.

The enclosed packet of material needs to be completed and returned to our office before an appointment can be scheduled. ****NOTE**** If this packet contains five Connors forms, they do not need to be returned with the packet, please bring them with you to the first appointment.

Obtaining as much information as possible regarding your child will assist us in performing an accurate and thorough assessment. Please complete the enclosed forms as accurately and completely as possible and return them in the enclosed envelope.

If your child has had any previous psychiatric or psychological assessments, or has been assessed for special services through school, please enclose copies of these reports as well.

We will ask you to sign a ***Patient Authorization for Disclosure of Health Information*** for your child's primary care physician in order to coordinate care.

**Psychiatry**

West Fee Hall
909 Wilson Road
Suite B119
East Lansing, MI 48824

(517) 353-3070
Fax: (517) 884-1817
healthcare.msu.edu
psychiatry.msu.edu

***Please note that your child will be seen for the purpose of assessment and treatment recommendations only. Decisions regarding continuing treatment will be made based on the assessment findings. Participation in the assessment does not mean that we are assuming ongoing care. ***

The Department of Psychiatry is a training institution. You will be scheduled with a Resident who is supervised by a licensed Psychiatrist. Note that a medical student may be observing in your care.

Thank you for your prompt consideration. If you have any questions, please feel free to contact us at (517) 353-3070.

*Nikki Peterson*

Intake Coordinator
Department of Psychiatry
Michigan State University
Telephone: 517-353-3070 Fax: 517-884-1817

MSU Health Care

# Patient Registration

Last Name: _____ First Name: _____

First Name Used: _____ DOB: _____ SSN: _____

Legal Sex: _____ Assigned at birth: _____ Gender Identity: _____

Preferred Pronoun: ☐ he/him ☐ she/her ☐ they/them

Sexual Orientation: ☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Secondary Number: _____

Email (Not parent email if minor): _____

Language Preference: _____

Race: _____ Ethnicity: _____

Marital Status: _____

PRIMARY INSURANCE

Holder: _____

Group #: _____

Policy: _____

SECONDARY INSURANCE

Holder: _____

Group #: _____

Policy: _____

EMERGENCY CONTACT

Name: _____

Relation: _____

Phone Number: _____

Secondary Number: _____

NEXT OF KIN

Name: _____

Relation: _____

Phone Number: _____

PARENT/GUARDIAN(S)

Parent/Guardian #1 Name: _____

Phone: _____ Email: _____

Street Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2 Name: _____

Phone: _____ Email: _____

Street Address (if different than patient): _____

City: _____ State: _____ Zip: _____

| Office Use Only | MRN | NP __ PASCA __ | BP | Wt | Ht |
|---|---|---|---|---|---|
| | | | | | |

# Michigan State University Department of Psychiatry
# Psychiatric Assessment Services for Children and Adolescents

Please help us become acquainted with your child & family by the answering the following questions as thoroughly as possible.

| Child's Name __ Male __ Female | Child's Date of Birth | Age | School | Grade |
|---|---|---|---|---|
| | | | | |

| Your Name | Home Address | Child's Pediatrician or Family Doctor |
|---|---|---|
| Relationship to Child | | Doctor's Address & Phone Number |
| Telephone __ Home __ Cell | | |

How did you hear of our clinic? __ Pediatrician/Family Doctor __ Therapist __ School __ Insurance __Other: _____

## BACKGROUND INFORMATION

Chief Complaint? Please provide a brief description of your concerns and/or the reason for your visit.

Does your child or has your child difficulty with any of the following? Check all that apply.

__ Sleep problems
__ Eating problems
__ Sadness/crying
__ Anger/irritability
__ Tantrums/rages
__ Feeling hopeless/guilty
__ Unable to enjoy activities
__ Harm to self
__ Harm to others or property
__ Inflated self confidence
__ Episodic increases in energy
__ Excessive worries or fears
__ Nervous habits
__ Repetitive thoughts or actions
__ Panic attacks
__ History of traumatic event(s)
__ Problems with friends
__ Problems in classroom
__ Frequent physical complaints
__ Attention/concentration
__ Repetitive movements or sounds
__ Defiance
__ School avoidance or truancy
__ Bullying others or being bullied
__ Tobacco, alcohol or drug use
__ Lying or theft
__ Excess concerns about weight
__ Bizarre ideas or experiences
__ Hallucinations
__ Special idiosyncracies
__ Sensory issues
__ Delays in development
__ Bedwetting or toileting issues
__ Nightmares
__ Snoring
__ Speech problems

Has your child ever been prescribed medications for this problem or mental health reasons? __Yes __No If yes, please complete the following:

| Name of Medication | Dates Taken | Prescribed by | Reason | Outcome |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Has your child been seen by a counselor/therapist in the past? __ Yes __ No If yes, please complete the following:

| Name | Dates Seen | Reason Seen | Type of Therapy |
|---|---|---|---|
| | | | |
| | | | |

Has your child been seen a psychiatrist in the past? __ Yes __ No If yes, please complete the following:

| Name | Dates Seen | Reasons and/or Diagnoses? |
|---|---|---|
| | | |
| | | |

Has your child ever been psychiatrically hospitalized? __ Yes __ No If yes, please complete the following:

| Name | Dates | Reasons and/or Diagnoses? |
|---|---|---|
| | | |
| | | |

Does your child drink caffeine (tea, pop, coffee, energy drinks, etc)? __ Yes __ No If so, how much? _____

Do you have any concerns about your child using drugs and/or alcohol? __ Yes __ No

If yes, please explain: _____

Do you have guns or other weapons in your home? __ Yes __ No

## MEDICAL HISTORY

When was child last seen by their doctor? _____ Reason? _____

Does your child have any health problems? __ Yes __ No If yes, please list:

_____

_____

| | | | | |
|---|---|---|---|---|
| Please circle if your child has had the following: | Chicken Pox | Measles | Mumps | Rheumatic Fever |
| | Scarlet Fever | Whooping Cough | Roseola | Polio |
| | Meningitis | Encephalitis | Tuberculosis | |
| Has your child ever experienced any of the following? | Hospitalization? | __ Yes __ No | Any accidents? | __ Yes __ No |
| | Surgery? | __ Yes __ No | Any head injuries? | __ Yes __ No |
| ** If yes to any, please describe below: | Heart problems? | __ Yes __ No | Had a seizure(s)? | __ Yes __ No |

_____

_____

Is child allergic to any medication(s)? __ Yes __ No If yes, please list: _____

Does child take any prescribed medication(s)? __ Yes __ No If yes, please list:

| Medication | Dose | How often | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Vaccinations up to date? __ Yes __ No __ Don't Know

Does child take vitamins, minerals or other non-prescription medications? __ Yes __ No Is so, list:

| Name | How often | Reason |
|---|---|---|
| | | |
| | | |
| | | |

## DEVELOPMENTAL HISTORY

Pregnancy Normal pregnancy? __ Yes __ No

If problems, please describe: _____

During pregnancy, did mother use any of the following? If yes, provide details regarding use, timing, amount, etc..

Medications? __ Yes __ No _____ Alcohol? __ Yes __ No _____

**Labor & Delivery**

Tobacco? __ Yes __ No _____ Illicit drugs? __ Yes __ No _____

Full Term? __ Yes __ No If no? __ Premature __ Overdue By how many weeks? _____

Labor __ Easy __ Difficult How many hours?_____ Baby's presentation? __ head first __ breech

Delivery? Vaginal __ C-section __ Induced? __ Yes __ No Birth Weight _____ lbs _____ oz

If C-section, why? _____

Following delivery, did your child...

Need supplemental oxygen? __ Yes __ No
Need blood transfusion? __ Yes __ No
Need X-rays, CT or MRI? __ Yes __ No
Show signs of birth trauma? __ Yes __ No
Have other complications? __ Yes __ No

**Newborn Period**

Did child exhibit the following? How long? How long?

__ Yes __ No Irritability _____
__ Yes __ No Vomiting _____
__ Yes __ No Convulsions/Seizures _____
__ Yes __ No Difficulty Breathing _____
__ Yes __ No Breastfeeding _____
__ Yes __ No Normal weight gain _____

**Development**

Any concerns your child was delayed in development? __ Yes __ No If yes, circle area(s) of concern: Motor / Language / Social

| | Age | | Age | | Age |
|---|---|---|---|---|---|
| Sitting without help | | Spoke single words | | Weaned | |
| Crawling | | Spoke in sentences | | Bladder Trained | |
| Walking | | Puberty | | Bowel Trained | |

In relationships to siblings and peers?

__ Plays individually __ Plays in groups
__ Competitive __ Cooperative
__ Leader __ Follower

**Education**

Types of Classes:

__ Regular Education __ Resource Room __ Alternative Education __ Home Schooling
__ Special Education __ Learning Disabled __ Emotionally Impaired __ 504 plan
__ Other - Please describe any additional interventions including school accommodations, tutoring, etc:

_____

Has your child had specific learning difficulties? __ Yes __ No Has your child undergone testing to evaluate? __ Yes __ No
If yes, please describe in detail below and bring copy of any testing results to your visit:

_____

Has your child ever skipped a grade? __ Yes __ No Repeated a grade? __ Yes __ No If yes to either, please describe:

_____

Name / title / phone number of person at school familiar with your child's behavior and academic performance.

_____

| | Name of School | City | Date Began | Date Ended | Grades completed at this school |
|---|---|---|---|---|---|
| Preschool | | | | | |
| | | | | | |
| Elementary | | | | | |
| | | | | | |
| Middle School | | | | | |
| | | | | | |
| High School | | | | | |
| | | | | | |

Please complete the following for current family situation. Additional lines available for stepparents, guardians, etc.

| Relation | Name | Age | DOB | Birthplace | Education | Occupation | Religion |
|---|---|---|---|---|---|---|---|
| Mother | | | | | | | |
| Father | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Parents: __ Married __ Separated __ Divorced If remarried or previously married, please provide dates:

Dates _____ _____ _____ Mother _____ Father _____

If parents not together, what is custody agreement? _____

__ Deceased M / F Date/Circumstances _____

Siblings – Please complete the following for all siblings.

| Name | Age | Sex | School or Occupation | Grade | Relationship (full, half, step, etc.) | Living at Home | Any Mental Illness? | Uses drugs or alcohol? |
|---|---|---|---|---|---|---|---|---|
| | | __M__F | | | | __Y__N | __Y__N | __Y__N |
| | | __M__F | | | | __Y__N | __Y__N | __Y__N |
| | | __M__F | | | | __Y__N | __Y__N | __Y__N |
| | | __M__F | | | | __Y__N | __Y__N | __Y__N |
| | | __M__F | | | | __Y__N | __Y__N | __Y__N |
| | | __M__F | | | | __Y__N | __Y__N | __Y__N |

Sources of family income? _____

Sources of family stress? _____

Living Arrangements – Please list all individuals residing in the home & their relationship to child?

_____ _____

_____ _____

_____ _____

_____ _____

Number of moves _____

| Location | Dates | House / Apt / Other | Rent / Own |
|---|---|---|---|
| | to | | |
| | to | | |
| | to | | |
| | to | | |

Has child ever lived away from family? __ Yes __ No If yes, explain: _____

If child is adopted?

Adoption Source _____ Age of child when first in home _____ Date of legal adoption _____

Reason/circumstance _____

What has child been told? _____

## LEGAL HISTORY

Has your child ever been:
In trouble with the police? __ Yes __ No
Arrested? __ Yes __ No
On probation? __ Yes __ No
Charged with a crime? __ Yes __ No
Convicted of a crime? __ Yes __ No
In juvenile detention or jail? __ Yes __ No

If yes to any of the above, describe: _____

## FAMILY HISTORY

Any family history of cardiovascular disease before age 35 including arrhythmia, fainting, sudden death, etc? __ Yes __ No

Please indicate any mental health history in each of the child's biological or blood relatives with an X in the corresponding column.

| | | | Paternal (father's) Family | | | | Maternal (mother's) Family | | |
|---|---|---|---|---|---|---|---|---|---|
| | Siblings | Father | Aunts / Uncles | Grand parents | Cousins / Other | Mother | Aunts / Uncles | Grand parents | Cousins / Other |
| Depression | | | | | | | | | |
| Anxiety | | | | | | | | | |
| Obsessions or Compulsions | | | | | | | | | |
| Mania or Bipolar Disorder | | | | | | | | | |
| Psychosis or Schizophrenia | | | | | | | | | |
| Attention or Concentration Problems | | | | | | | | | |
| Hyperactivity Problems | | | | | | | | | |
| Learning Problems | | | | | | | | | |
| Mental Retardation | | | | | | | | | |
| Alcohol Problems | | | | | | | | | |
| Drug Use Problems | | | | | | | | | |
| Legal Problems | | | | | | | | | |
| Abuse or Neglect | | | | | | | | | |
| History of suicide attempts | | | | | | | | | |
| History of harming self | | | | | | | | | |
| History of harming others | | | | | | | | | |
| History of psychiatric hospitalization | | | | | | | | | |
| Use of psychiatric medication | | | | | | | | | |

## REVIEW OF SYSTEMS:

Please check box marked YES if your child has experienced any of the following. If not, leave blank.

YES — GENERAL
- ☐ Fevers/chills?
- ☐ Weight loss?
- ☐ Changes to energy level?

YES — HEENT
- ☐ Glasses?
- ☐ Hearing problems?
- ☐ Ear infections and/or ear pain?
- ☐ Seasonal/environmental allergies?
- ☐ Strep throat?
- ☐ Sinus problems?

YES — NEURO
- ☐ Vision changes or problems?
- ☐ Head injury?
- ☐ Trouble walking?
- ☐ Seizures?
- ☐ Headaches?
- ☐ Numbness/tingling?
- ☐ Clumsiness/balance problems?

YES — CV
- ☐ Chest pain?
- ☐ Fainting?
- ☐ Feeling heart beating or racing?
- ☐ Problems with blood pressure?
- ☐ Heart murmur?

YES — PULM
- ☐ Wheezing or asthma?
- ☐ Trouble breathing at rest?

YES — ENDO
- ☐ Intolerance to heat or cold?
- ☐ Unusual weight changes?
- ☐ Problems with blood sugar?
- ☐ History of diabetes?

YES — HEME
- ☐ Bleeding problems?
- ☐ Abnormal bruising?

YES — GI
- ☐ Frequent stomachaches?
- ☐ Nausea and/or vomiting?
- ☐ Diarrhea?
- ☐ Constipation?

YES — GU
- ☐ Problems urinating?
- ☐ Bladder or kidney infections?
- ☐ Nighttime incontinence?

YES — MSK
- ☐ Joint pains or swelling?
- ☐ Growing pains?
- ☐ Muscle weakness?

YES — SKIN
- ☐ Rashes?
- ☐ Picking?
- ☐ Large or unusual birthmarks?

# PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

MSU Health Care

Patient Name (Last, First, Middle) _____

Date of Birth: _____ Phone # _____

I authorize the disclosure of my protected health information between the parties below:

| | |
|---|---|
| Department of Psychiatry | _____ |
| 909 Wilson Rd, West Fee Hall Room B119<br>Address | _____<br>Address |
| East Lansing, MI 48824-6537<br>City, State, Zip Code | _____<br>City, State, Zip Code |
| Phone: (517) 353-3070<br>Fax: (517) 884-1817<br>Phone/Fax Number | Phone:<br>Fax:<br>Phone/Fax Number |

SEND RECORDS TO _____ REQUEST RECORDS FROM _____ (PLEASE MARK ONE)

SPECIFY THE INFORMATION TO BE DISCLOSED: Please specify date(s)

☐All of my behavioral health information _____

☐Ongoing Communication, as needed, between the parties named above _____

☐Progress Notes / Encounters _____ ☐Treatment Summaries _____

☐Psychiatric / Psychological Assessments _____

☐Psychological Testing _____ ☐Psychotherapy Notes _____

☐Lab Reports _____ ☐Immunizations _____

☐ Medications _____ ☐Consultations _____

☐Information from other healthcare providers/facilities (please specify)_____

☐Other (please specify)_____

PURPOSE OF THIS DISCLOSURE:

☐Continuing Care ☐Insurance ☐Legal ☐Disability ☐Patient Request ☐Workers Comp

Other (please specify)_____

I UNDERSTAND that if the person/entity that receives this information is not a health care provider or health plan covered by Federal privacy regulations, the information described above may not be protected from further disclosures.

I UNDERSTAND that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, except in very limited circumstances. I may inspect or receive a copy of the information disclosed in accordance with this Authorization.

I UNDERSTAND that I may revoke this Authorization at any time by contacting the Psychiatry Clinic except to the extent that action has been taken in reliance on this Authorization. This Authorization expires _____ (or one year from the date signed).

_____ _____

Signature of Patient or Personal Representative (Required) Date (Required)

_____

Name of Personal Representative and Relationship to Patient (or description of authority to act on behalf of the patient

| Patient | |
|---|---|
| MRN | |

# MSU DEPARTMENT OF PSYCHIATRY FINANCIAL POLICY

Thank you for choosing the Michigan State University Department of Psychiatry. We are committed to providing our patients with the best possible care and minimizing administrative costs. Please review the information below.

- Insurances vary in their coverage, and it is the **patient's responsibility** to understand his/her mental health benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. **Patients are responsible for any co-payments and deductibles at the time of service. This is an insurance company policy.** Payment for professional services can be made with cash, check, VISA, MasterCard, Discover, or American Express.

- We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for psychiatric care is a contract between **you** and the **carrier**. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

- Our staff is happy to help with insurance questions related to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by your insurance company. Please contact Customer Service at the number listed on your insurance card.

- You will be asked to review your information, including demographics and insurance information, every year. Out of date information can cause unnecessary delays in the payment of your claim.

- **No Insurance:** Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our billing office.

- **Missed Appointments/Late Cancellations:** Missed appointments (no-shows) or appointments not cancelled with 24 hours' notice will be charged a $50 no-show fee. Charges for missed appointments are not covered by insurance. The charge will be billed directly to you, and you will be required to pay this fee prior to your next appointment. Recurrent no-shows (more than 2 within 6 months) or cancellations (more than 3 in 6 months) will result in a discharge from care.

- **Outstanding Balances:** We urge you to keep your account current. Account balances past due over 120 days will be sent to an outside agency for collection, at which time you will be discharged from care. Payment arrangements can be made with our Billing Office at (517) 884-2998.

Again, thank you for choosing us as your healthcare provider.

_____ _____

Patient/Parent/Guardian signature Date

**MSU Psychiatry Clinic**

| Patient | |
|---|---|
| MRN | |

# No-Show Policy

Quality care for our patients is our top priority. Please take a few minutes to review our No-Show policy and sign at the bottom of the form. If you have any questions, please let us know.

## Definition of a No-Show Appointment

MSU Psychiatry Clinic defines a No-Show appointment as any scheduled appointment in which the patient either:
- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 10 minutes late and is consequently unable to be seen.

## Impact of a No-Show Appointment

No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to show up for a scheduled appointment it:
- Potentially jeopardizes the health of the patient.
- Is unfair (and frustrating) to other patients who would have taken the appointment slot.
- Is disrespectful of the provider's time.

## How to Avoid Getting a No-Show

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

## 1. Appointment Confirmation

MSU Psychiatry Clinic will attempt to contact you 2-3 business days before your scheduled appointment to confirm your visit. If our automated system is unable to confirm with you over the phone, we will leave a message with your appointment date and time.

## 2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our clinic 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, and to complete any necessary paperwork before the scheduled visit.

## 3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care, as well as giving us the opportunity to rebook the vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call at 517-353-3070.

## Consequences of No-Show Appointments

1. You will be charged a $50 no-show fee for each missed appointment.
2. If you miss 3 or more appointments within a year, you will be discharged from the clinic.
3. If you are discharged from the clinic, your remaining scheduled appointments will be cancelled.
4. Only emergency medical treatment will be offered within the first 30 days of discharge.

I have read and understand the MSU Psychiatry Clinic "No Show" policy as described above.

Patient/Guardian Signature _____ Date _____