Welcome to
Focus & Balance LLC

CHILDREN'S PACKAGE

ATTENTION PATIENTS

Here at Focus & Balance LLC we strive to bring quality psychiatric care to all patients. Our providers believe in quality and will take their time with each patient as well as with you. Please understand that there are certain circumstances that your provider will take longer than expected. Each and every patient is very important to our office. We appreciate your patience.

Please keep in mind that it is crucial for **YOU** the patient to be as sincere about your life and illness with your provider. Not doing so, will affect your medical treatment. At any point in time, if it comes to the attention of the clinic you are not being genuine this may be ground for discharge. Be advised if there is any mention of finding another provider this will be automatically considered a voluntary discharge. Your case will be closed **NO EXCEPTION**.

I have read and understood the information above

____ _____/______/_______

Parent or Legal Guardian Signature Date

PATIENT APPOINTMENT POLICY

We strive to provide our patients with quality and professional psychiatric services. Your adherence to the recommended number of appointments is a vital component to your mental and physical health. It is the patient's responsibility to come to their appointments; a reminder card will be given for your future appointments as well as a reminder call.

When our office books your appointment, we are setting aside a dedicated time slot just for you. We ask that if you need to reschedule or cancel your appointment that you please provide us with at least a 24 hour notice. There is a **charge of $85** for not showing up for a scheduled appointment or for not canceling within the 24 hour grace period we have provided for you. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee.

I have read and understood the information above

____ ____/____/____

Parent or Legal Guardian Signature Date

FOCUS AND BALANCE, LLC
PATIENT REGISTRATION FORM

CREDIT CARD AUTHORIZATION

In adherence to our clinics policy, we ask each patient to keep credit/debit card on file for any outstanding balances from our clinic. You will be notified by our staff of any charges made to your account.

I,___________________________________(print name as it appears on the credit/debit card), authorize Focus & Balance LLC, to submit any charges for professional services including cancellation/no show fees that are rendered to_______________________________________(print full legal name of patient receiving services) to my credit/debit card. This authorization applies to all legitimate charges for any individual whom I have accepted financial responsibility and includes all current and future outstanding charges.

Name on Credit/Debit Card: _________________________________

Circle One: M/C VISA DISC AMEX

Card Number: ____ Expiration Date: ___/____

By signing below you agree and consent our clinic to charge your credit/debit card for any outstanding charges occurred from any service fees including cancellation/no show fees.

I have read and understood the information above

____ ___/___/___

Parent or Legal Guardian Signature Date

COURT SUMMONS FEE

In the event the providers are summoned to court to testify on your behalf. You agree to pay a fee of $1500.00 per day to Focus & Balance LLC for this service to offset the cost. (I.e. CPS cases, Child Custody Cases)

____ _____/______/______

Parent or Legal Guardian Signature Date

EFFECTIVE AUGUST 16, 2013

Focus & Balance will **NO** longer fill out F.M.L.A or Short term disability

I___________________________________, understand that Focus & Balance LLC no longer will fill out F.M.L.A. or Short term disability forms.

____ _____/______/______

Parent or Legal Guardian Signature Date

PHYSICIAN ASSISTANT CONSENT FORM

This facility has on staff a physician assistant to assist in the delivery of psychiatric care. A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a physician assistant can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care. Supervision does not require the constant presence of the supervising physician, rather the overseeing of activities of and accepting responsibility for the medical services provide. A physician assistant may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing mental status exams
- Ordering and/or performing diagnostics and therapeutic procedures
- Formulation and working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medication and writing prescriptions (where allowed by the law)
- Making appropriate referrals

I____have read the above, and hereby consent to the services of a physician assistant for my health care needs. I understand that at any time I can refuse to see the physician assistant and request to see a Physician.

____ _____/______/______

Parent or Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

UNDERSTANDING YOUR HEALTH RECORDS & INFORMATION:

Each time you visit our clinic a record of your visit is made. Typically this record contains interval history, goals, medications, assessments, and a plan for future care or treatment. This information is referred to as medical records. Medical records are used for:

- Means of communication among health care professionals who contribute to your care.
- Legal documentation describing the care you have received
- Means by which a third-party payer can verify that services were actually provided
- Tool by which we can assess and continually work to improve the care we render and out comes we achieve

OUR RESPONSIBILITY:

- Maintain the privacy of your health records
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Accommodate reasonable requests you may have to communicate your health information
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain a current copy of this notice is available upon request

PATIENT RIGHTS

- You have the right to obtain a paper copy of the notice of private policies upon request.
- You have the right to inspect and copy your health record.
- You have the right to obtain an accounting of disclosures of your health information

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

____

Parent or Legal Guardian Signature Date

I,____, acknowledge that I

(Print Parent or Legal Guardian Name)

Has either received a copy of this office’s NOTICE OF PRIVACY PRACTICES or that this office’s

NOTICE OF PRIVACY PRACTICES was made available to me to receive records.

FOCUS AND BALANCE, LLC
PATIENT REGISTRATION FORM

PATIENT INFORMATION			**TODAY'S DATE:**
LAST NAME:	SUFFIX:	FIRST NAME:	MIDDLE NAME:
ADDRESS:	CITY:	STATE:	ZIP:
HOME:	MOBILE:	WORK:	
SOCIAL SECURITY #:	DOB:	SEX: ☐ M ☐ F	
MARITAL STATUS (CHECK ONE): ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOW			
EMERGENCY CONTACT			
NAME:			
RELATION:	HOME PHONE:	CELL PHONE:	
TREATMENT AND MEDICAL INFORMATION			
PRIMARY CARE:	PHONE:		
THERAPIST (IF ANY) :	PHONE:		
PRIMARY INSURANCE			
PLAN NAME:	INSURED NAME:		
ADDRESS:	CITY:	STATE:	ZIP:
INSURED'S SOCIAL SECURITY # :	INSURED'S DOB:	SEX: ☐ M ☐ F	
POLICY/ID#:	GROUP#:		
SECONDARY INSURANCE			
PLAN NAME:	INSURED NAME:		
ADDRESS:	CITY:	STATE:	ZIP:
INSURED'S SOCIAL SECURITY # :	INSURED'S DOB:	SEX: ☐ M ☐ F	
POLICY/ID#:	GROUP#:		

IMPORTANT NOTICE

I understand the initial evaluation at Focus & Balance LLC is only an evaluation and will be used to determine if a treatment plan can be achieved. I understand that all fees for all services are non reimbursable and at the conclusion of the initial evaluation that further treatment may or may not be possible. I understand that if any clinician at Focus & Balance LLC suggests hospitalization for the patient's safety and the patient either refuses hospitalization, the clinician is forced to call authorities for patient's safety or the patient leaves hospitalization against medical advice the patient is subject to being discharge from our clinic. I understand that if any clinician with Focus & Balance LLC request a urine drug screen (UDS), planned or random and the patient refuses to complete the UDS on the day requested or the UDS returns positive without the patient's disclosure of usage the patient is subject to immediate discharge from our clinic. I understand that in the event a prescription is lost, stolen, damaged or you miss your appointment for refills you will not receive early refills. By signing below I acknowledge and understand the information above.

____ ____________________
Signature of Parent or Legal Guardian Date

NAME:

IN YOUR OWN WORDS, PLEASE DESCRIBE THE MAIN REASON FOR YOUR CHILD'S VISIT:

ANXIETY

DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF ANXIETY-EXPLAIN:

INTENSITY FROM 1 TO 10 (10 BEING THE WORST):

FREQUENCY:

___DAILY ___WEEKLY ___MONTHLY

ADHD/ADD

DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF ADHD/ADD-EXPLAIN:

BIPOLAR

DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF BEING BIPOLAR-EXPLAIN:

INTENSITY FROM 1 TO 10 (10 BEING THE WORST):

FREQUENCY:

___DAILY ___WEEKLY ___MONTHLY

DEPRESSION

DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF DEPRESSION-EXPLAIN:

INTENSITY FROM 1 TO 10 (10 BEING THE WORST):

FREQUENCY:

___DAILY ___WEEKLY ___MONTHLY

EATING DISORDER

DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF AN EATING DISORDER-EXPLAIN:

INTENSITY FROM 1 TO 10 (10 BEING THE WORST):

NAME:
FREQUENCY: ___DAILY ___WEEKLY ___MONTHLY
OBSESSIVE COMPULSIVE DISORDER (OCD)
DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF OCD-EXPLAIN:
INTENSITY FROM 1 TO 10 (10 BEING THE WORST):
FREQUENCY: ___DAILY ___WEEKLY ___MONTHLY
PSYCHOSIS
DOES YOUR CHILD CURRENTLY OR EVER HAD: ___HALLUCINATIONS ___HEARING VOICES ___PARANOIA ___OTHER(EXPLAIN):
PANIC ATTACKS
DOES YOUR CHILD CURRENTLY OR EVER HAD SYMPTOMS OF PANIC ATTACKS-EXPLAIN:
INTENSITY FROM 1 TO 10 (10 BEING THE WORST):
FREQUENCY: ___DAILY ___WEEKLY ___MONTHLY
SLEEP ISSUES
DOES YOUR CHILD CURRENTLY OR EVER HAD ANY ISSUES WITH GOING OR STAYING ASLEEP-EXPLAIN:
INTENSITY FROM 1 TO 10 (10 BEING THE WORST):
FREQUENCY: ___DAILY ___WEEKLY ___MONTHLY

NAME:

MENTAL HEALTH HISTORY

PLEASE INDICATE IF YOUR CHILD HAVE BEEN TREATED FOR ANY PSYCHIATRIC CONDITION:

___YES ____NO

PLEASE LIST BELOW:

PSYCHIATRIC HOSPITALIZATIONS

____YES ____NO

FOR WHAT REASON(S):

HOW MANY TIMES:

HOW LONG:

HAS YOUR CHILD EVER TRIED TO HARM THEMSELVES: ___YES ___NO

HAS YOUR CHILD EVER TRIED TO HARM OTHERS: ___ YES ___NO

PREVIOUS PSYCHIATRIC MEDICATION(S):

FAMILY PSYCHIATRIC HISTORY

PLEASE INDICATE IF ANYONE IN YOUR FAMILY HAS BEEN DIAGNOSED OR TREATED WITH A PSYCHIATRIC DISORDER/CONDITION:

MEDICAL HISTORY

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS? IF YES, WHAT HAVE THEY BEEN DIAGNOSED WITH:

PLEASE LIST ANY CURRENT MEDICATION(S)AND DOSAGE:

DOES YOUR CHILD HAVE ANY ALLERGIES TO ANY MEDICATION(S)? IF YES PLEASE LIST:

NAME:
SUBSTANCE ABUSE HISTORY
HAS YOUR CHILD EVER TRIED ANY ILLEGAL SUBSTANCES (IE: MARIJUANA, COCAINE, HEROINE, METH ETC.)? IF YES INDICATE WITH WHAT SUBSTANCE, HOW LONG AND IF THEY HAVE RECEIVED ANY TREATMENT IN THEPAST(WHERE/WHEN):
DOES YOUR CHILD DRINK ANY BEVERAGES WITH CAFFEINE ? IF YES HOW MANY PER DAY/WEEK/MONTH:
SOCIAL HISTORY
LEVEL OF EDUCATION: ___ ELEMENTARY ___MIDDLE SCHOOL ___HIGH SCHOOL
LEGAL HISTORY:
CURRENT SITUATION AT HOME (I.E., SUPPORTIVE, STRAINED, ETC.):

MOOD DISORDER QUESTIONNAIRE (MDQ)

NAME: ____ DATE: ________________

Instructions: Check the answer that best applies to you. Please answer each question as best you can.

1. Has there ever been a period of time when you were not your usual self and…	YES	NO
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? …you were so irritable that you shouted at people or started fights or arguments? …you felt much more self-confident than usual? …you got much less sleep than usual and found you didn't really miss it? …you were much more talkative or spoke much faster than usual? …thoughts raced through your head or you couldn't slow your mind down? …you were so easily distracted by things around you that you had trouble concentrating or staying on track? …you had much more energy than usual? …you were much more active or did many more things than usual? …you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? …you were much more interested in sex than usual? …you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? …spending money got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
3.How much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fights? Please mark on response only: ☐No Problem ☐ Minor Problem ☐ Moderate Problem ☐Serious Problem		
4. Have any of your blood relatives (i.e. children, sibling, parents, grandparents, aunts, and uncles) had manic – depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

ADHD/ADD QUESTIONNAIRE

NAME: ____ DATE: ___________________

Instructions: The items below refer to how you have behaved and felt DURING MOST OF YOUR ADULT LIFE. If you have usually been one way and recently have changed, your responses should reflect HOW YOU HAVE USUALLY BEEN. Rate each of the questions using the following scale:

0 = Not at all 1 = Just a little 2 = somewhat 3 = moderately 4 = Quite a lot 5 = Very much

1. At home, work, or school, I find my mind wandering from tasks that are uninteresting or difficult.	
2. I find it difficult to read written material unless it is very interesting or very easy.	
3. Especially in groups, I find it hard to stay focused on what is being said in conversations.	
4. I have a quick temper...a short fuse.	
5. I am irritable, and get upset by minor annoyances.	
6. I say things without thinking, and later regret having said them.	
7. I make quick decisions without thinking enough about their possible bad results	
8. My relationships with people are made difficult by my tendency to talk first and think later.	
9. My moods have highs and lows	
10. I have trouble planning in what order to do a series of tasks or activities.	
11. I easily become upset.	
12. I seem to be thin skinned and many things upset me	
13. I almost always am on the go	
14. I am more comfortable when moving than when sitting still	
15. In conversations, I start to answer questions before the questions have been fully asked.	
16. I usually work on more than one project at a time, and fail to finish many of them	
17. There is a lot of "static" or "chatter" in my head.	
18. Even when sitting quietly, I am usually moving my hands or feet	
19. In group activities it is hard for me to wait my turn	
20. My mind gets so cluttered that it is hard for it to function.	
21. My thoughts bounce around as if my mind is a pinball machine	
22. My brain feels as if it is a television set with all the channels going at once	
23. I am unable to stop daydreaming.	
24. I am distressed by disorganization	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ____ DATE: ____________

Instructions: Over the last 2 weeks, how often have you been bothered by any of the following problems? Check the number below to indicate you answer.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgetyor restless that you have been moving around a lotmore than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**

Add columns ______ **+** ______ **+** ______

TOTAL:

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at how, or get Along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____