CADENZA CENTER FOR PSYCHOTHERAPY & THE ARTS, INC.

CHILD INTAKE

Date:____/_____/_____

Name:_____Date of Birth:____/____/_____

Age:_____ School: _____ Grade: _____

PRIMARY LANGUAGE: ☐ English ☐ Spanish ☐ Other
_____

Address:_____

City/State/Zip:_____

Phone: Home: (_____)_____-_____ Work:(_____)_____-_____ Cell:(____):_____-_____

E-mail: _____Phone # for session reminder: _____

Emergency Contact: Name:_____ -Select One-) Phone:(____)_____-_____

Presenting Problem: _____

_____

Diagnosis, if any: _____

Date Diagnosed: _____ by: _____

Services requested: _____

FAMILY HISTORY

Place of Birth: City _____ State _____ Country _____

If not local, date of arrival to South Florida: _____/_____/_____ **Reason for move:** _____

Religious/Cultural/Ethnic factors affecting patient's status: _____

_____

PARENTS: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced (child's age at divorce: _____)

Parent #1's Name:_____ Lives w/Patient? -Sele Date of Birth: ___/_____/_____

Parent #2's Name:_____ Lives w/Patient? -Sele Date of Birth: ___/_____/_____

Step Parent:_____ Lives w/Patient? -Sele Date of Birth: ___/_____/_____

Describe time-sharing (if child lives in more than one home): _____

SIBLINGS Name	Age	Lives with Patient?
1.		-Select One-
2.		-Select One-
3.		-Select One-
4.		-Select One-

History of Physical Abuse/Family Violence or Neglect: -Select One- Has abuse been reported? -Select One-

Charges Pending? -Select One- Patient was: -Select One-

History of Sexual Abuse/Trauma: -Select One- Has abuse been reported? -Select One-

Charges Pending? -Select One- Patient was: -Select One-

History of Violence: -Select One- , toward: -Select One- Other:

History of Cruelty to Animals and/or Fire Setting: -Select One- explain:

History of Risk Taking Behaviors, General Behavioral Problems or Unusual/Bizarre Behaviors: -Select One-

Explain (provide time frames/dates):

Previous In/Outpatient Treatment – Including psychiatric hospitalization :

MEDICAL& DEVELOPMENTALHISTORY

Pregnancy: ☐ Planned ☐ Unplanned Reaction to pregnancy: _____

Pregnancy, Labor and Delivery: ☐ Normal ☐ Complications, describe: _____

_____

Description of Child as a Baby/Toddler: _____

_____

Were developmental milestones met as expected (walked, talked, toileting, feeding, self-care) describe: _____

_____

Has your child had surgery or head injuries? ☐ No ☐ Yes, explain (include dates): _____

_____

_____

Pediatrician/Family Practitioner: _____ **Phone:** _____

Psychiatrist (if applicable): _____ **Phone:** _____

Current medications:

1. _____ Dose:_____ For:_____
2. _____ Dose:_____ For:_____
3. _____ Dose:_____ For:_____

Describe Disciplinary Methods, by whom, is it effective: _____

_____

Family History of significant Medical Conditions/Illnesses: _____

_____

Family History of Alcohol/Substance Abuse, Psychological/Learning Issues (including Anxiety, Depression, ADHD, Autism, Schizophrenia, Suicide, etc.):

_____

_____

_____

Toilet Training: ☐ Normal ☐ Not Achieved Age when achieved: _____ Still Bed wetting:

Eating Habits: ☐ Normal ☐ Irregular, describe: _____

Sleeping Habits: ☐ Normal ☐ Irregular, describe: _____

CURRENT THERAPY OR SERVICES:

Please list all current services your child receives on a weekly basis.

THERAPY	DATE STARTED	# OF SESSIONS EACH WEEK	TOTAL MINUTES PER WEEK	THERAPIST / AGENCY AND PHONE NUMBER
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Behavior Therapy				

ACADEMIC HISTORY

Classroom/Program: ☐ Typical ☐ Special Needs ☐ Home-School **Does your child like school?** ☐ No ☐ Yes
Academic performance: ☐ Excellent ☐ Satisfactory ☐ Unsatisfactory, explain:

_____

History of repeating grade(s): ☐ No ☐ Yes, explain:

_____

History of school problems. (Circle all that apply, explain):
School phobia, disruptive, needs frequent teacher attention, defiant, truancy, skipping class, suspension, expelled

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

_____

_____

_____

Is there suspected bullying? ☐ No ☐ Yes **Description of social relationships/friends.** _____

Previous Academic Placements:

SCHOOL NAME	START / END	TYPE OF PROGRAM	REASON LEFT

What does your child enjoy doing during free time: _____

_____

Current extracurricular activities: _____

What are your child's strengths: _____

_____

What are your child's weaknesses: _____

_____

What other information should we know about your child to better understand your concerns? _____

_____

_____

Completed By: _____ Date:___/___/___
PRINT NAME

_____
SIGNATURE

_____ (Initial) By completing this form and putting my signature above, I acknowledge that I am consenting for treatment, evaluation, and/or consultation for the above-mentioned individual and that I have the authority to give such consent.

Cadenza Center for Psychotherapy & the Arts, Inc.
Client Rights, Responsibilities, and Consent for Treatment

Client Name:_____ Responsible Party Social Security Number _____-_____-_____

As a potential client of Cadenza Center for Psychotherapy & the Arts , Inc., I understand that I am assured humane and dignified treatment at all times and the following rights, and I agree to the following responsibilities.

Rights:
1. Right to refuse and/or terminate treatment at any time.
2. Right to informed consent.
3. Right to confidentiality whereby the information revealed by me during treatment will be kept strictly confidential (understanding that any pertinent information relative to my care will be documented in a Cadenza Center for Psychotherapy & the Arts, Inc. contact record) and will not be revealed to anyone without my written authorization. The law provides the following exceptions to this provision:
   a. If Cadenza Center for Psychotherapy & the Arts , Inc. has knowledge of client's intent to harm self or others.
   b. If Cadenza Center for Psychotherapy & the Arts, Inc. has knowledge of child abuse, neglect or exploitation.
   c. If Cadenza Center for Psychotherapy & the Arts, Inc. receives a court-order to the contrary.
   d. If client enters into litigation with Cadenza Center for Psychotherapy & the Arts, Inc.
   e. If medical emergency necessitates disclosure.
   f. If Cadenza Center for Psychotherapy & the Arts, Inc. has knowledge of client's intentional spreading of communicable disease
4. Right to request second opinion.
5. Right to treatment without regard to race, color, sex, age, religion, national origin, disability or sexual orientation.

Parent/Legal Guardian/Client Responsibilities:
1. To keep predetermined appointment and to notify Cadenza Center for Psychotherapy & the Arts, Inc. at least 24 hours in advance of canceling or rescheduling an appointment.
2. To participate and follow agreed upon treatment.
3. To maintain confidentiality pertaining to group therapy, when applicable.
4. To assume responsibilities for payment of the assessed and agreed fees for services.
5. To inform Cadenza Center for Psychotherapy & the Arts, Inc. of any change in address and phone numbers.

Notice of Privacy Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessment and physician/non-physician certifications.

My signature below indicates that I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of health information. I understand that this organization has right to change it **Notice of Privacy**

Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations. I also understand that the Cadenza Center for Psychotherapy & the Arts, Inc may not be legally required to agree to my requested restrictions.

Consent for Treatment:
I understand and voluntarily agree to the above, and I authorize evaluation and/or treatment by Cadenza Center for Psychotherapy & the Arts. I understand that this consent can be repealed in writing at any time during the treatment period.

Name of the Client/Parent/Legal Guardian: _____Date:___/___/___

Signature:_____Date:___/___/___

CADENZA CENTER FOR PSYCHOTHERAPY & THE ARTS, INC.

Financial Responsibility Agreement

Client Name: _____Responsible Party Social Security Number _____-_____-_____

The following is a statement of our financial policy, which we require you to read and sign prior to receiving non-emergent care.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we accept Visa, Mastercard, cash, money orders or checks. Non-payment of fees may result in the interruption of your services.

I understand that I am responsible to meet my insurance deductible and make co-payments as required by my plan in addition to any services provided that are not covered by my insurance carrier. This will be explained to me prior to my first appointment if possible. The staff at the Cadenza Center strive to obtain the most accurate insurance information from insurance companies, however from time to time, the information provided may be inaccurate. I also understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed even when benefits have been discussed with my carrier in advance of my first appointment. Therefore, in the event that my insurance carrier refuses to make payment against claims made for services rendered to myself and/or my family (regardless of reason – i.e., deductible, inaccurate copay information, inaccurate number of sessions approved), I understand that I am responsible for prompt payment (within 2 weeks of written notice) for these services received. I understand that I am entitled to a detailed description of the charges in dispute. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed on my behalf, I will immediately pay over such payments to the Cadenza Center for Psychotherapy and the Arts, Inc.

I understand that in order to receive the best clinical services, my therapist may be available for brief phone sessions to speak with me or other professionals involved in my care when necessary. In addition, my therapist may prepare letters, treatment summaries, preparation of records, or other services I request. I understand that these services and time are not billable to my insurance carrier and therefore I am responsible for payment for services lasting more than 15 minutes. My therapist or office staff will advise me of any fees applied to my account. I understand that I will be billed a pro-rated fee for these services based upon my therapist's customary session fee.

Because scheduled sessions are reserved specifically and exclusively for me and/or my family, I understand that *unless my session is canceled with at least 24 hours in advance, I may be charged a the FULL FEE for missed appointments*. Only my therapist may make exceptions and waive the fee, at his/her discretion, for emergency or unusual circumstances. I am aware that insurance carriers do not provide reimbursement for cancelled or missed sessions. Additionally, repeated missed appointments may result in termination of therapy. I understand that my therapist and the staff at the Cadenza Center will always make every effort to notify me and reschedule any appointments that need to cancelled in case of an emergency.

The Cadenza Center reserves the right to refer any unpaid balance to an outside collection agency and to take appropriate legal action to collect unpaid balances. I know that I will be responsible for payment of all fees and costs associated with these collection efforts, including payment of any court costs and attorney's fees. **I understand that unpaid balances greater than 30 days may be subject to a late fee of the greater of $25 or 2% of the outstanding balance. I agree to pay a $1.50 statement fee for outstanding balances carried past 60 days.**

A photocopy of this authorization is as valid as if it were an original executed document. I authorize the release of payments and medical information necessary to process my and/or my family members' insurance claims and related claims. I hereby authorize payment directly to my therapist or to Cadenza Center for Psychotherapy and the Arts, Inc. of the insurance benefits otherwise payable to me for all professional services received.

I have read the financial policy and had an opportunity to have question answered. I understand and voluntarily agree to this financial policy.

Name of Client/Guardian: _____ Date: ___/___/___

Signature: _____ Date: ___/___/___