

The Northshore Group

Date: _____ Clinician: _____

Child Information

Name _____ Age _____ Birth date _____ Sex M F

Address _____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

School _____ Grade _____ Social Security No. _____ - -

Parent and/or Guardian Information

Father _____ Age _____ Birth date _____

Home Phone* _____ Office Phone* _____ Cell/Pager _____

Address _____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

Social Security No. _____ - - Religion _____ Education _____

Occupation _____ Employer _____

Marital Status S M W D Sep Date: _____ Previous Marriages _____

Mother _____ Age _____ Birth date _____

Home Phone* _____ Office Phone* _____ Cell/Pager _____

Address _____
(STREET) (APT #) (CITY & STATE) (ZIP CODE)

Social Security No. _____ - - Religion _____ Education _____

Occupation _____ Employer _____

Marital Status S M W D Sep Date: _____ Previous Marriages _____

Other _____ Relationship _____

Home Phone* _____ Office Phone* _____ Cell/Pager _____

Emergency Contacts

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Siblings and Relatives

<u>Name</u>	<u>Relationship</u>	<u>Age/DOB</u>	<u>Education</u>	<u>Occupation</u>	<u>Residence</u>
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Referral Information

Source of Referral _____

Previous Psychiatric Sources Used _____

Family Physician _____ Office Phone _____

Would you like us to bill your insurance for you? Yes No If yes, please present card.

Have you called your insurance company for authorization (if required)? Yes No

OFFICE USE ONLY:

Dx: _____

CPT: _____

Charge: _____

THE NORTSHORE GROUP
1111 NORTSHORE DRIVE - SUITE SOUTH 490
KNOXVILLE, TN 37919-4054
VOICE - (865)584-0171 FAX - (865)584-0174

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Communication between your clinician here at The Northshore Group and other healthcare providers (i.e. primary care physician and other mental health providers) is important to make sure all care is complete, comprehensive, and well-coordinated. No information will be released without your signed authorization.

- Name of patient: _____ DOB: ___ / ___ / ___ SSN: _____-____-_____
- I authorize The Northshore Group / _____ to disclose protected health information about [myself / my minor child / my legal charge] (circle one):
- This information should only be released to:

PCP / Clinician: _____ Phone / Fax _____

Address: _____

- I am requesting the release / communication of this information to the above provider to ensure the quality and coordination of care.
- Any applicable behavioral health information, including diagnosis, treatment plan, prognosis, and medication(s) will be communicated between healthcare providers.
- This authorization shall remain in effect until _____ (fill in a date or an event).
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address above. I also understand that my revocation will not be effective to the extent that action has already been taken in reliance on the authorization.
- I understand that a mental health professional generally may not condition services upon my signing an authorization such as this.
- I understand that information used or disclosed according to the authorization may be re-disclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature of patient (or parent or legal guardian)

Relationship to patient

Date

Patient's Rights and Responsibilities Statement

Statement of Patient's Rights

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law may records be released without member permission.
- Easily access timely care.
- Know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Patient's Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Patient's Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and the provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of the care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Patient Signature

Date

Provider Signature

Date

The Northshore Group

Child/Adolescent Developmental History

Patient Name: _____ Age: _____ Sex: _____

Date of Birth: _____ Date: _____

What was your child's birth weight?

_____ lbs. _____ oz. Unknown

Was delivery normal?

Yes Unknown

No; specify _____

Did the birth mother experience any physical or emotional problems during pregnancy?

Yes; specify _____

No Unknown

Were medications taken during pregnancy?

Yes; specify _____

No Unknown

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?

Yes; specify _____

No Unknown

Did the baby experience any problems immediately after birth?

Yes; specify _____

No Unknown

Has your child ever required hospitalization?

Yes; specify _____

No Unknown

Is there any history of physical, sexual or emotional abuse?

Yes; specify _____

No Unknown

Is there a history of prolonged separations or traumatic events?

Yes; specify _____

No Unknown

At what age did your child do the following?

(Italicized areas reflect normal development)

_____ smiled (6 mths)

_____ sat alone (6 to 10 mths)

_____ talked in sentences (30 to 36 mths)

_____ walked by self (12 mths)

_____ held head up (3 to 4 mths)

_____ fed self (2yrs)

_____ crawled (6 to 10 mths)

_____ rode a bike (6 yrs)

_____ rolled over (6 mths)

_____ talked in single words (18 to 24 mths)

_____ pulled up (6 to 10 mths)

_____ established toilet training (2 ½ to 4 yrs)

How would you describe your child's approach to new situations?

Positive, jumps right in

Withdrawn, tends not to participate

Slow to warm up; cautious

How would you generally describe your child's overall mood?

Positive (happy, laughing, upbeat, hopeful)

Negative (depressed, cranky, angry, hostile)

Mixed but more positive, than negative

Mixed but more negative than positive

Which school is your child currently attending?

Is your child currently receiving special services in this school?

Yes; specify _____

No

Has your child ever failed a class or been held back for academic reasons?

Yes; specify grade: _____

No

Is your child expected to pass this school year?

Yes

No