



## Client Care Form

### Client Information

Client First Name \_\_\_\_\_

Client Last Name \_\_\_\_\_

Client DOB \_\_\_\_\_ Other Sex/Gender Info? \_\_\_\_\_

Legal Sex \_\_\_\_\_

Full Address \_\_\_\_\_

Preferred Name \_\_\_\_\_

Client Phone ☐ \_\_\_\_\_

Email Client ☐ \_\_\_\_\_

Client School \_\_\_\_\_ Grade? \_\_\_\_\_

### Communication Preferences

We may use all of the following to contact you. Please indicate if **you would like to opt OUT** of one of the following methods by listing it below.

Phone Call / Email / Text Message

Preferred method of contact?: \_\_\_\_\_

Additional Information? \_\_\_\_\_

Opt OUT: \_\_\_\_\_

### Payment Information

Our office requires a credit card to be placed on file at the time of scheduling. Please be prepared to give this information to our clinic coordinator at the time of

### Guarantor for Payment

☐ Guarantor Same as Client?

Relationship to Client \_\_\_\_\_

Guarantor First Name \_\_\_\_\_

Guarantor Last Name \_\_\_\_\_

☐ Address Same as Client?

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Guarantor Phone \_\_\_\_\_

Guarantor Email \_\_\_\_\_

### Parent (1) Info Relationship to Client \_\_\_\_\_

Full Name \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

### Parent (2) Info Relationship to Client \_\_\_\_\_

Full Name \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

### Emergency Contact (if other than parent)

Relationship to Client \_\_\_\_\_

Contact Full Name \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

#### Custody/Legal Agreement?

☐ Not Applicable

☐ Yes\*

#### Medical Decision-Making Rights?

☐ Not Applicable?

☐ Full\* ☐ Joint\*

*\*NOTE: If you marked yes or full/joint to either question above, we require documentation of arrangements prior to your appointment.*

# INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Printed Client Name

Date of Birth

I understand that by signing this document, I agree to become a client of Music City Peds (either me or a minor member of my family). As an MCP client, I am eligible to receive a range of services, the type and extent of which will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me or my family member. I understand that typically treatment is provided over the course of several weeks or months. If I agree to allow Music City Peds to manage the medicine for me or my family member, I am aware that I will pay for follow-up appointments at the frequency recommended, at least every 3 months (for maintenance dosing).

I understand that all information shared with clinicians at Music City Peds is confidential and no information will be released without my consent. During the course of treatment at Music City Peds, it may be recommended for my provider to communicate with other providers involved in my care. In this case, consent to release information is given through written authorization.

Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. When there is a risk of imminent danger to me or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or disabled adult is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or disabled adult and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at Music City Peds, I may discuss them with my provider. I have read and understand the above and I consent to participate in the evaluation and treatment offered to me by Music City Peds. I understand that I may stop treatment at any time.

## ACKNOWLEDGEMENT OF NOTICE OF POLICIES AND PRACTICES

My signature below indicates that I have read and understood the **Business Policies** of Music City Peds. My signature below also indicates that I have been provided an opportunity to review the **Notice of Policies and Practices to Protect the Privacy of Your Health Information**. Both are also available on our website. *(For example, our policy states that to avoid being charged a \$100 late cancellation or no-show fee, you must contact us 24 hours prior to your scheduled appointment to make changes.)*

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

Client Signature (only necessary if 16yo+)

Date

Provider Signature

Date



## RELEASE OF INFORMATION FORM

### Authorization for Disclosure

This form, when completed and signed, provides authorization for **Music City Peds** to release and/or receive protected health information (PHI) from your clinical record to/from the person(s) designated within this document.

Client Name \_\_\_\_\_ Client Date of Birth \_\_\_\_\_

Please check the box(es) indicating what can be **released to** OR **received from** the following parties:

<p><b>PRIMARY CARE PROVIDER</b></p> <p>Name: _____</p> <p>Company: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p><input type="checkbox"/> ALL <input type="checkbox"/> Evaluations/Office Visit Notes <input type="checkbox"/> Lab Results</p> <p><input type="checkbox"/> Educational Info <input type="checkbox"/> Former Records/Testing</p>	<p><b>REFERRING CLINICIAN</b></p> <p>Name: _____</p> <p>Company: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p><input type="checkbox"/> ALL <input type="checkbox"/> Evaluations/Office Visit Notes <input type="checkbox"/> Lab Results</p> <p><input type="checkbox"/> Educational Info <input type="checkbox"/> Former Records/Testing</p>
<p><b>OTHER</b></p> <p>Name: _____</p> <p>Company: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p><input type="checkbox"/> ALL <input type="checkbox"/> Evaluations/Office Visit Notes <input type="checkbox"/> Lab Results</p> <p><input type="checkbox"/> Educational Info <input type="checkbox"/> Former Records/Testing</p>	<p><b>OTHER</b></p> <p>Name: _____</p> <p>Company: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p><input type="checkbox"/> ALL <input type="checkbox"/> Evaluations/Office Visit Notes <input type="checkbox"/> Lab Results</p> <p><input type="checkbox"/> Educational Info <input type="checkbox"/> Former Records/Testing</p>

- I understand the purpose of this authorization of information is to improve planning for treatment.
- I understand this release form covers the period from: *Specific Date(s)*: \_\_\_\_\_ to \_\_\_\_\_ **OR** (initial here) \_\_\_\_\_ *All past, present and future encounters/visits*
- I understand that I have the right to revoke this authorization by providing written notification to the **Music City Peds** office address listed below. However, this authorization may not be revoked if **Music City Peds** has taken action on this authorization prior to receiving my written notice.
- I further understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
- I understand that any personal health information or other information released to **Music City Peds** may be subject to re-disclosure by **Music City Peds** and may no longer be protected by applicable federal and state privacy laws.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

Client Signature (only if over 18)

Date

# ACKNOWLEDGEMENT OF SUBSTANCE USE POLICY

## for clients 16yo+ and a caregiver

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Printed Client Name

Date of Birth

I understand that all clients 16yo+ (and a caregiver until client turns 18yo) will be asked to sign written informed consent to treatment and acknowledgement of our policies and privacy practices at the start of treatment and periodically throughout treatment. This includes acknowledgement of our substance use policy:

I understand that illicit substances and substances that are misused or non-prescribed can be detrimental to me or my child's brain and may cause serious, sometimes fatal, health effects, especially when used in combination with other substances, including prescription medications. I understand that my clinician at Music City Peds cannot ensure optimal treatment when non-prescribed substances interfere with symptoms or response to medication. I agree to disclose all known prescribed and non-prescribed medications that I have or my child has used so that my child's clinician can be aware of drug interactions and safety risks. I understand that my clinician will take substance use into consideration when determining an appropriate treatment plan. My clinician may order drug tests when clinically warranted and may decide to discontinue treatment or refer to another specialist if necessary. If a substance use disorder is suspected to be my or my child's primary diagnosis, my clinician will refer to a specialist as Music City Peds does not provide treatment for substance use disorders.

I also understand that the information I share/my child shares with his or her clinician is confidential and can only be shared with other professionals, parents or caregivers with his or her permission, with the exceptions to confidentiality listed on consent form. If a referral must be made or treatment discontinued, your clinician will talk privately with him or her to determine what information may be shared with parents or caregivers to explain this treatment decision.

If I have any questions regarding this form or about the services offered at Music City Peds, I may discuss them with my provider. I have read and understand the above and I consent to participate in the evaluation and treatment offered to me by Music City Peds. I understand that I may stop treatment at any time.

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Parent/Guardian Signature

Parent/Guardian Printed Name

Date

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Client Signature

Client Printed Name

Date

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Provider Signature

Date



## Intake Questionnaire

This form is designed to 1) provide an opportunity for caregivers to communicate useful information about their child and 2) allow our providers to review this information prior to your visit to ensure the most effective use of our appointment time. Please fill out what is applicable for your child. Thank you, and we look forward to meeting you!

### Contact Information:

Child/Client's Name:

Date of Birth:

Home Address:

Child/Client's Phone Number (if applicable):

Child/Client's Email (if applicable):

Parent/Guardian 1:

Parent/Guardian 2:

Phone Number:

Phone Number:

Email:

Email:

Are there any custody or legal documents regarding medical decision-making for this child?

☐ No   ☐ Yes - please attach

### Reason for Visit

How did you hear about our practice?

What are your main concerns about your child?

When did you first notice these concerns?

What are your goals for this visit?

## Birth History

Is your child adopted? ☐ No ☐ Yes If yes, age at adoption:

Any fertility treatments used? ☐ No ☐ Yes (Specify)

Any complications during pregnancy? ☐ No ☐ Yes (Specify)

Delivery Method: ☐ Vaginal ☐ Cesarean

Gestational age: ☐ at term ☐ premature (\_\_\_ weeks)

Birth weight:

Any medical complications during or shortly after delivery? ☐ No ☐ Yes (Specify)

Did child require NICU or extended hospital stay? ☐ No ☐ Yes (Specify why)

Feeding method: ☐ Breastmilk ☐ Formula ☐ Both

Any feeding problems after birth? ☐ No ☐ Yes (Specify)

## Social History

Who lives at home?

Language(s) spoken at home:

Parental Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Never Married

Siblings (names and ages):

Any additional caregivers routinely involved in child's care? ☐ No ☐ Yes (Specify)

Any significant conflict between family members?

Any cultural or religious beliefs that are important to your family?

Any significant moves or relocations for the child/family?

Any significant past or recent grief or loss?

Any history of trauma or major adjustment periods?

## Family History

Please check boxes below and specify which family member(s) to the right if child has family history of any of the following:

☐ Genetic Syndromes

☐ Intellectual Disability

☐ Developmental Delays

- ☐ Autism
- ☐ ADHD
- ☐ Learning disability
- ☐ Anxiety
- ☐ Depression
- ☐ OCD
- ☐ Suicide
- ☐ Substance Use Disorder
- ☐ History of Wolff Parkinson White or Long QT Syndrome or other cardiac arrhythmias

Explain:

- ☐ Early cardiac death (before age 55yo)
- ☐ Other:

## Medical History

Primary Care Provider:

Allergies:

Chronic medical conditions:

Past Surgeries or Hospitalizations:

Current medications:

Hearing: ☐ Normal ☐ Concerns (Specify)

Vision: ☐ Normal ☐ Concerns (Specify)

Sleep concerns: ☐ Sleeps well ☐ Difficulty falling asleep ☐ Wakes during night ☐ Snoring

Appetite concerns: ☐ Good appetite ☐ Selective eater ☐ Restricted food interests

Any GI or toileting complaints? ☐ stomach aches ☐ constipation ☐ bedwetting ☐ soiling

Other:

## Developmental History

Briefly describe any notable details about your child's early development.

Were milestones (sitting, walking, talking, toileting) generally on time? ☐ Yes ☐ No

If not, please describe:

Has your child ever received early intervention, speech, occupational, or physical therapy?

☐ No ☐ Yes — please describe:

## Mental Health History

Diagnosed developmental or mental health disorders:

If so, where and how were diagnoses assessed (school evaluation, psychoeducational testing, past medical providers/specialists, pediatrician, etc.)?

\*If possible, please provide relevant records from former diagnostic assessments.

Please list current mental health medications and how your child is responding to each:

Please list past mental health medications and reasons they were stopped:

Please list other current or past mental health providers (psychiatrists or therapists):

## School and Learning

Current school:

Grade:

Teacher:

Has your child ever repeated a grade? ☐ No ☐ Yes

Has your child ever received a psychoeducational evaluation or learning assessment? ☐ No ☐ Yes - please attach

Does your child have any diagnosed learning disabilities? ☐ No ☐ Yes — please describe:

Has your child been tested for giftedness? ☐ No ☐ Yes — please describe:

Does your child have an IEP or 504 plan? ☐ No ☐ Yes - please attach

How does your child do academically?

Any behavior or attention concerns at school?

Any problems with school attendance/avoidance/refusal?

Any concerns about homework?



## Behavioral Patterns

Check any that apply to your child:

- |  |  |
|--|--|
| <input type="checkbox"/> Easily frustrated     | <input type="checkbox"/> Agitation/irritability      |
| <input type="checkbox"/> Short attention span  | <input type="checkbox"/> High activity level         |
| <input type="checkbox"/> Impulsivity           | <input type="checkbox"/> Aggression                  |
| <input type="checkbox"/> Rigid routines        | <input type="checkbox"/> Frequent tantrums/meltdowns |
| <input type="checkbox"/> Sensory sensitivities | <input type="checkbox"/> Sleep difficulties          |
| <input type="checkbox"/> Anxiety or worry      | <input type="checkbox"/> Sadness                     |
| <input type="checkbox"/> Perfectionism         | <input type="checkbox"/> Oppositional or defiant     |
| <input type="checkbox"/> Difficulty with peers | <input type="checkbox"/> Low self-esteem             |

Any particular triggers for your child?

What strategies help your child when they are upset?

## Getting to Know Your Child

How would you describe your child's temperament? (intense, cautious, easy going, reactive)

What are your child's favorite activities or interests?

What are some of your child's strengths or best qualities?

What are some ways you connect with your child?

Are there any significant life events or influences that have shaped your child's development?

Anything else you would like us to know?