Serenity Health Center, PA

Psychiatry Clinic Intake Questionnaire

(Please print clearly and complete all pages)

Child's Name:				Today's Date:	
Last	First		Middle		
Legal Guardian's Name:		-			
Home Address:					
Telephone No:	Cell No:	Apt #		State	Zip
SS No:	Sex:	M F Date	e of Birth:/	/ Race:	
Email:	Alle	rgies:			
Social Status Child is: Still at Home	School	Working			
Child's place of Education:		Address		City	
Child's place of Employment:					
Name Who referred you to this office?		Address		City	
Who is child's Pediatrician?	Name			Telephone #	
For what problem(s) with your child d	Name lo you seek h	relp?		Telephone#	
What led you to seek help now?	-				
What makes the problem worse?					
What makes the problem better?					
What goal(s) do you hope psychiatric	treatment w	ill help?			
What form of treatment do you expect	for your chi	ld (psychoth	erapy, medica	tion, other)?	
How long do you think this will take?					

	Parent(s)/Legal Guardian/Re	esponsible Party
Relationship to Patient: Se	f Spouse Parent Othe	er
Name:		Relationship to Patient:
Address:	4	
City:	State: Zip:	Phone: ()
Employer	Work Phone ()	SSN#
	Billing/Insurance Info	ormation
Policy Holder	DOB	Relationship to Patient
SSN#:	Name of Employer:	Work Phone: ()
Address of Employer:	City_	State:Zip
Insurance Company	Grp #	ID#
Ins Co Address:		Ins Phone:
DO YOU HAVE SECOI	NDARY INSURANCE? Yes No IF	YES, COMPLETE THE FOLLOWING
Name of Insured	DOB	
Relationship to Patient	SSN#:	
Name of Employer:	Work #: ()	
Address of Employer:	City	State:Zip
Insurance Company	Grp #	ID#
Ins #:		

MR #(For office use only.)			DATE: / /
PAR	ENT-REPO	RT QUI	ESTIONNAIRE
DEMOGRAPHICS:			
Child's Name (last, first, mi)			• • • • • • • • • • • • • • • • • • • •
Address			
G.y	State	_ Zip Cod	e
Phone Number: home ()	_ work (_	
Person Completing this form:		Re	lationship to child:
Sex: M F Date of birth:	//	Age at ad	lmission: years months
Race: R 1=White 2=African-American 3=Hispanic 4=Asian 5=Native-American 6=Pacific Islander 0=Other	teligion: 1=Catholic 2=Protesta: 3=Jewish 4=Agnostic 0=Other	nt	Living Situation: 1=Both Biological Parents 2=Single Parent: Mother 3=Single Parent: Father 4=Parent & Step-Parent 5=Other
Who lives in the same househo	ld as the chil	d?:	
NAME	SEX	AGE	RELATIONSHIP TO CHILD

NAME	SEX	AGE	RELATIONSHIP TO CHILD

PATIENT NAME:	MR #
Father's highest education received: N	10ther's highest education received:
1=less than 7 years of schooling	5=technical school
2=junior high school	6=partial college
3=partial high school	7=college graduate
4=high school graduate	8=professional degree
Father's Current Occupation: M	Nother's Current Occupation:
1=Executive, Professional	5=Skilled
2=Manager/Lesser Professional	6=Semi-skilled
3=Administrator/Minor Professional	7=Unskilled
4=Clerical/Sales	8=Student
	9=Never worked
	Why?
Father's perferred hand: M	lother's perferred hand:
Child's Last Grade Completed	Special Ed: Yes No
Name of School	
Has your child ever repeated a grade? Yes	No
If was which grade and why?	
If yes, which grade and why?	
DEVELOPMENTAL HISTORY: (Not all pare	ents remember the answers to these questions.
You can write down what you do remember i	now or you can look in the baby book, if you
kept one.)	
1. What was the length of the pregnancy? _	
2. Were any medications used during pregr	angui? Voc. No. 16 was what ?
2. Were any medications used during pregi	nancy? Yes No If yes, what?
2. Ware forces used at delivery? Ver	No. Not and D. It K
3. Were forceps used at delivery? Yes	No Not sure Don't Know
4. Any other complications of delivery?	
Premature rupture of membras	ne Extraction
Twins or Triplets	Hemorrhage
Version	High Blood Pressure
5. How much did the baby weigh at birth?	
6. Did the baby start breathing right away?	Yes No Not sure Don't Know
7. Did the haby cry? Yes No Not su	re Don't Know

8.	Were there any problems with the baby after s/he wa	s bom?
	Incubator	Jaundice
	Blueness or trouble breathing	Convulsions
	Hyaline membrane disease	Trouble feeding
	Other:	(breast or bottle)
9.	When did the baby leave the hospital?	
10.	When the baby came home, were there any problems	s?
	Colic, excessive irritability or crying	Slept too little
	. Sleepiness, too quiet, lethargy	Too floppy
	Poor feeding	Too stiff
11.	When did the baby really smile (not "gas")?	market and the second s
12.	When was the baby able to sit by him/herself WITHO	OUT PROPPING OR HELP?
13.	When did the baby start to walk by him/herself WITH	HOUT HOLDING ON?
14.	When did the baby say his/her first word?	_
15.	When did the baby say short sentences like: "I want n	nilk" or "go bye bye"?
16.	Did the child have trouble learning to speak? Yes	No
	Was s/he different from brother or sisters or other	children?
17.	Is the child toilet trained? Yes No If yes, how	old when trained?
18.	How old was the child when s/he was able to:	
	Ride a tricycle?	
	Ride a byicycle without training wheels?	
	Get dressed by him/herself?	
•	Tie shoelaces?	
19.	What hand does the child prefer to use?	_
	At what age did you notice this? before I year after?	2 years after 4 years
20.	Anything else significant occur during the child's dev	velopment years?

PATIENT NAME:_					MR #	
MEDICAL HISTORY	γ.					
Does your child hav		history	of the follow			
Does your chird hav	carry	mstory	of the follow	ing:		
			At what	✓ if still		
Illness	No	Yes	Age(s)?	present	Comments	
Allergies (describe)						
Asthma						
Chicken Pox						
Complications at						
Birth						
Convulsions,						
Seizures, Epilepsy						
Dizziness or						
Fainting						
Head Injury			-			
High Blood						
Pressure						
Loss of						
Consciousness					1	
Low Blood						
Pressure						
Measles		*			,	
Other Serious						
Illness:			6			
Other Serious						
Illness:						
Respiratory						
Illness						
Rheumatic Fever						
Sleep Problems						
Urogenital						
Problems						
Vision Problems		į				
(e.g. Lazy eye)						
MEDICAL PROCEDU	RES:					
las your child ever h	ad sur	gery (ar	operation)?	•		
		_	nd give date			
Туре		Da	ate	Comments		
					0	

is your clima, area and	serious injuries?	AND DESCRIPTION OF THE PERSON			
No Yes If yes, des	cribe and give da	tes below:			
Туре	Date	Commen	its		
-78					
your child currently taking					
No Yes If yes, plea	ase list:				
Name Dose	Dat	e Started	Reason		
rls only <i>(circle appropriate</i> Has your daughter h If Yes, age	ad her 1st period	? No	Yes		
Has your daughter h If Yes, age Are period Date of last mens Is there an	ad her 1st period ds regular?	? No	Yes ty with perio		
Has your daughter h If Yes, age Are period Date of last mens Is there an	ds regular? strual period ny change in symes, please describe	? No No ptom severi	Yes ty with perio		
Has your daughter h If Yes, age Are period Date of last mens Is there an	ds regular? strual period y change in sym es, please describe ty that your daug	? No No ptom severi	Yes ty with perio		
Has your daughter h If Yes, age Are period Date of last mens Is there an If Yes	ds regular? strual period y change in sym es, please describe ty that your daug	? No No ptom severi	Yes ty with perio		
Has your daughter h If Yes, age Are period Date of last mens Is there an If Yes Is there any possibility UROPSYCHIATRIC HISTORY s your child ever: made involuntary body me	ds regular? strual period by change in sym es, please describe ty that your daug ORY:	? No No ptom severie ther is preg	Yes ty with perionant? No	Yes	
Has your daughter h If Yes, age Are period Date of last mens Is there an If Yes Is there any VICTORISTORY So your child ever:	ds regular? strual period by change in sym es, please describe ty that your daug ORY:	? No No ptom severie ther is preg	Yes ty with perionant? No	Yes	
Has your daughter h If Yes, age Are period Date of last mens Is there an If Yes Is there any possibility UROPSYCHIATRIC HISTORY s your child ever: made involuntary body me	ds regular? strual period by change in sym es, please describe ty that your daug ORY: ovements or sou	? No No ptom severie ther is preg	Yes ty with perionant? No	Yes	
Has your daughter h If Yes, age Are period Date of last mens Is there an If Yes Is there any possibility UROPSYCHIATRIC HISTORY s your child ever: made involuntary body mens Age of first tic(s): years	ds regular? strual period y change in sym es, please describe ty that your daug ORY: ovements or sou	? No No ptom severie chter is preg	Yes ty with perionant? No	Yes	
Has your daughter h If Yes, age Are period Date of last mens Is there an If Yes Is there any VEROPSYCHIATRIC HISTORY So your child ever: made involuntary body mentage of first tic(s): years	ds regular? strual period y change in sym es, please describe ty that your daug ORY: ovements or sou please describe	No No ptom severie there is preg	Yes ty with period nant? No	Yes	

PA	ATTENT NAME:				MR #		-
3.	had repetitive or excessions:		-				
4.	had problems with atterance of 1st symptoms:				•		
5.	been diagnosed with a le	_					
6.	had other emotional or l Age of 1st symptoms:		-		Yes		
Ha	ve you ever sought profe No Yes If	ssional trea			d for any of th	e above probl	ems?
	Problem (Diagnosis)	Start Date	Stop Date	Type (see scale below)	Inpatient, Outpatient, or Day Hospital?	Benefit (scale at bottom of page)	

1=Drug Therapy, 2=Talk Therapy, 3=Behavior Therapy, 4=Other (specify)

Benefit Rating Scale:

Good, Fair, Poor

MEDICATION HIS	TORY	1						
Has your child ever	been	treat	ed for en	notional	or psycl	niatric proble	ms with n	nedication?
If yes, please con	mnlet	einfo	rmation	in the ta	ble belo	tar:		
MEDICATIONS	T		IMIACION	Start	Stop		Benefit	6:1
MEDICATIONS	No	Yes	Dose	Date	Date	Diamenia		Side
	140	165	Duse	Date	Date	Diagnosis	(scale below)	Effects
AN'II-								
DEPRESSANTS								
Amitriptyline								
(Elavil)			-					
Bupropion								
(Wellbutrin)								
Clomipramine								
(Anafranil)				,				
Desipramine								
(Norpramin)	-							
Fluoxetine (Prozac)								
Fluvoxamine								
(Favaran)								
Imipramine								
(Tofranil)								
Nortriptyline		1						
(Pamelor)								
Paroxetine (Paxil)								
Sertraline								
(Zoloft)								
Other:								
ANTIANXIETY/								
SLEEP DRUGS								
Buspirone (Buspar)								
Clonazepam								
(Klonopin)								
Lorazepam (Ativan)		-						
Other:								
ANTI-								
PARKINSONIAN								
Benztropine								
(Cogentin)								
Diphenhydramine								
(Benadryl)								
Other:								
	r							
				fit Ratin				
			G	ood, Fair,	Poor			

PATIENT NAME:_____

PATIENT NAME:	MR #

MEDICATIONS				Start	Stop		Benefit	Side
(con't)	No	Yes	Dose	Date	Date	Diagnosis	(scale below)	Effects
ANTI-								
PSYCHOTICS								
Clozapine								
(Clozaril)								
Fluphenazine								
(Prolixin)								
Haloperidol								
(Haldol)								
Pimozide			•					
(Orap)				·				
Thioridazine					-			
(Mellaril)								
Thiothixene								
(Navane)								
Other:								
MOOD -								
STABILIZERS								
Lithium								
Other:								
STIMULANTS			7					
Amphetamine							·	
(Dexedrine)								
Methylphenidate								
(Ritalin)								
Pemoline								
(Cylert) Other:								
MISCELLANEOUS								
Clonidine								
(Catapres) Hydroxyzine	\dashv							
(Atarax)		1						
Naltrexone								
Dilantin								
(Phenytoin)	-							
Valproic Acid (Depakene)		-		.				
Other:	-							
Ouici.						·		

Benefit Rating Scale: Good, Fair, Poor

PATIENT NAME:			MR #	
FAMILY HISTORY		-		
Is your child adopted?	No	Yes		
Have any of the child's bi				

No Yes

If yes, fill in table below:

Name			Father's	Mother's		Received
(or initials)	Age	Relationship	Side	Side	Diagnosis	Therapy?
			AND THE PROPERTY OF THE PROPER			
,		·				
						-
				· saanaacti		
		•				

How would you describe family life? 1=Stable 2=Unstable

Has the child experienced any of the difficulties listed in the table below?

No Yes
If yes, check all that apply.

		Child's	Duration
(V)		Age	
	1. Death of a parent		n/a
-	2. Death of other loved one/close friend.		n/a
	3. Separation from parent or family		
	4. Parents' separation/divorce		n/a
	5. Loss of Home		
	6. Family financial problems	,	
	7. Physical abuse		
	3. Sexual abuse		
). Parent with substance abuse problem		
1). Conflicts with parents		
1	. Removal of child from home		
1	. Victim of crime or violence		n/a
13	. Unwanted pregnancy		n/a
1.	. School problems		
13	. Illness in self		
16	. Illness in family (specify)		
17	. Other		

For office	µse:		181
Reviewed	by	Date reviewed	

Screen for Child Anxiety Related Disorders (SCARED) Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name:	
Date:	

Directions:

Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	0	0	0
2. My child gets headaches when he/she is at school.	0	0	0
3. My child doesn't like to be with people he/she doesn't know well.	0	0	0
4. My child gets scared if he/she sleeps away from home.	0	0	0
5. My child worries about other people liking him/her.	0	0	0
6. When my child gets frightened, he/she feels like passing out.	0	0	0
7. My child is nervous.	0	0	0
8. My child follows me wherever I go.	0	0	0
9. People tell me that my child looks nervous.	0	0	0
10. My child feels nervous with people he/she doesn't know well.	0	0	0
11. My child gets stomachaches at school.	0	0	0
12. When my child gets frightened, he/she feels like he/she is going crazy.	0	0	0
13. My child worries about sleeping alone.	0	0	0
14. My child worries about being as good as other kids.	0	0	0
15. When he/she gets frightened, he/she feels like things are not real.	0	0	0
16. My child has nightmares about something bad happening to his/her parents.	0	0	0
17. My child worries about going to school.	0	0	0
18. When my child gets frightened, his/her heart beats fast.	0	0	0
19. He/she gets shaky.	0	0	0
20. My child has nightmares about something bad happening to him/her.	0	0	0

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True or Hardly Ever True	Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	0	0	0
22. When my child gets frightened, he/she sweats a lot.	0	0	0
23. My child is a worrier.	0	0	0
24. My child gets really frightened for no reason at all.	0	0	0
25. My child is afraid to be alone in the house.	0	0	0
26. It is hard for my child to talk with people he/she doesn't know well.	0	0	0
27. When my child gets frightened, he/she feels like he/she is choking.	0	0	0
28. People tell me that my child worries too much.	0	0	0
29. My child doesn't like to be away from his/her family.	0	0	0
30. My child is afraid of having anxiety (or panic) attacks.	0	0	0
31. My child worries that something bad might happen to his/her parents.	0	0	0
32. My child feels shy with people he/she doesn't know well.	,0	0	0
33. My child worries about what is going to happen in the future.	0	0	0
34. When my child gets frightened, he/she feels like throwing up.	0	0	0
35. My child worries about how well he/she does things.	0	0	0
36. My child is scared to go to school.	0	0	0
37. My child worries about things that have already happened.	0	0	0
38. When my child gets frightened, he/she feels dizzy.	0	0	0
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)	0	0	0
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	0	0	0
41. My child is shy.	0	0	0

SCORING

A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific.

A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatic Symptoms.

A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder.

A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder.

A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder.

A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

CHILDREN'S DEPRESSION INVENTORY



NAME:	DATE:
Kids sometimes	have different feelings and ideas.
sentence that de	he feelings and ideas in groups. From each group, pick one scribes you best for the past two weeks. After you pick a sentence oup, go on to the next group.
There is no right the way you have	t answer or wrong answer. Just pick the sentence that best describes been recently.
Fill in the circle	O next to the sentence that you pick for your answer.
	ple of how this form works. Try it. Fill in the circle next to the scribes you best.
Example:	O I read books all the time.
	O I read books once in a while.
	O I never read books.
and here is th	ne filled-in circle!

REMEMBER, PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

- 1. O I AM SAD ONCE IN A WHILE.
 - O I AM SAD MANY TIMES.
 - O I AM SAD ALL THE TIME.
- 2. O NOTHING WILL EVER WORK OUT FOR ME.
 - O I AM NOT SURE IF THINGS WILL WORK OUT FOR ME.
 - O THINGS WILL WORK OUT FOR ME O.K.
- 3. O I DO MOST THINGS OK.
 - O I DO MANY THINGS WRONG.
 - O I DO EVERYTHING WRONG.
- 4. O I HAVE FUN IN MANY THINGS.
 - O I HAVE FUN IN SOME THINGS.
 - O NOTHING IS FUN AT ALL.
- 5. O I AM BAD ALL THE TIME.
 - O I AM BAD MANY TIMES.
 - O I AM BAD ONCE IN A WHILE.
- 6. O I THINK ABOUT BAD THINGS HAPPENING TO ME ONCE IN A WHILE.
 - O I WORRY THAT BAD THINGS WILL HAPPEN TO ME.
 - O I AM SURE THAT TERRIBLE THINGS WILL HAPPEN TO ME.
- 7. O I HATE MYSELF.
 - O I DO NOT LIKE MYSELT.
 - O I LIKE MYSELF.
- 8. O ALL BAD THINGS ARE MY FAULT.
 - O MANY BAD THINGS ARE MY FAULT.
 - O BAD THINGS ARE NOT USUALLY MY FAULT.
- 9. O I DO NOT THINK ABOUT KILLING MYSELF.
 - O I THINK ABOUT KILLING MYSELF BUT I WOULD NOT DO IT.
 - O I WANT TO KILL MYSELF.
- 10. O I FEEL LIKE CRYING EVERYDAY.
 - O I FEEL LIKE CRYING MANY DAYS.
 - O I FEEL LIKE CRYING ONCE IN A WHILE.

REMEMBER, PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

- 11. O THINGS BOTHER ME ALL THE TIME.
 - O THINGS BOTHER ME MANY TIMES.
 - O THINGS BOTHER ME ONCE IN A WHILE.
- 12. O I LIKE BEING WITH PEOPLE.
 - O I DO NOT LIKE BEING EITH PEOPLE MANY TIMES.
 - O I DO NOT WANT TO BE WITH PEOPLE AT ALL.
- 13. O I CANNOT MAKE UP MY MIND ABOUT THINGS.
 - O IT IS HARD TO MAKE UP MY MIND ABOUT THINGS.
 - O I MAKE UP MY MIND ABOUT THINGS EASILY.
- 14. O I LOOK OK.
 - O THERE ARE SOME BAD THINGS ABOUT MY LOOKS.
 - O I LOOK UGLY.
- 15. O I HAVE TO PUSH MYSELF ALL THE TIME TO DO MY SCHOOLWORK.
 - O I HAVE TO PUSH MYSELF MANY TIMES TO DO MY SCHOOLWORK.
 - O DOING SCHOOLWORK IS NOT A BIG PROBLEM.
- 16. O I HAVE TROUBLE SLEEPING EVERY NIGHT.
 - O I HAVE TROUBLE SLEEPING MANY NIGHTS.
 - O I SLEEP PRETTY WELL.
- 17. O I AM TIRED ONCE IN A WHILE.
 - O I AM TIRED MANY DAYS.
 - O I AM TIRED ALL THE TIME.
- 18. O MOST DAYS I DO NOT FEEL LIKE EATING.
 - O MANY DAYS I DO NOT FEEL LIKE EATING.
 - O I EAT PRETTY WELL.
- 19. O I DO NOT WORRY ABOUT ACHES AND PAINS.
 - O I WORRY ABOUT ACHES AND PAINS MANY TIMES.
 - O I WORRY ABOUT ACHES AND PAINS ALLT THE TIME.
- 20. O I DO NOT FEEL ALONE.
 - O I FELL ALONE MANY TIMES.
 - O I FEEL ALONE ALL THE TIME.

REMEMBER, PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

- 21. O I NEVER HAVE FUN AT SCHOOL.
 - O I HAVE FUN AT SCHOOL ONLY ONCE IN A WHILE.
 - O I HAVE FUN AT SCHOOL MANY TIMES.
- 22. O I HAVE PLENTY OF FRIENDS.
 - O I HAVE SOME FRIENDS BUT WISH I HAD MORE.
 - O I DO NOT HAVE ANY FRIENDS.
- 23. O MY SCHOOL WORK IS ALRIGHT.
 - O MY SCHOOL WORK IS NOT AS GOOD AS BEFORE.
 - O I DO VERY BADLY IN SUBJECTS I USED TO BE GOOD IN.
- 24. O I CAN NEVER BE AS GOOD AS OTHER KIDS.
 - O I CAN BE AS GOOD AS OTHER KIDS IF I WANT TO.
 - O I AM JUST AS GOOD AS OTHER KIDS.
- 25. O NOBODY REALLY LOVES ME.
 - O I AM NOT SURE IF ANYBODY LOVES ME.
 - O I AM SURE THAT SOMEBODY LOVES ME.
- 26. O I USUALLY DO WHAT I AM TOLD.
 - O I DO NOT DO WHAT I AM TOLD MANY TIMES.
 - O I NEVER DO WHAT I AM TOLD.
- 27. O I GET ALONG WITH PEOPLE.
 - O I GET INTO FIGHTS MANY TIMES.
 - O I GET INTO FIGHTS ALL THE TIME.

SUM:	

ADMINISTRATION:

0 INDIVIDUAL

(Circle One)

1 GROUP

Kovacs, M. & Beck, A. T. (1977) © Copyright 1982 by Maria Kovacs, PhD

Version:

Screen for Child Anxiety Related Disorders (SCARED) Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name:	
Date:	

Directions

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Not True or Hardly Ever True	Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.	0	0	0
2. I get headaches when I am at school.	0	0	0
3. I don't like to be with people I don't know well.	0	0	0
4. I get scared if I sleep away from home.	0	0	0
5. I worry about other people liking me.	0	0	0
6. When I get frightened, I feel like passing out.	0	. 0	0
7. I am nervous.	0	0	0
8. I follow my mother or father wherever they go.	0	0	0
9. People tell me that I look nervous.	0	0	0
10. I feel nervous with people I don't know well.	0	0	0
11. I get stomachaches at school.	0	0	0
12. When I get frightened, I feel like I am going crazy.	0	0	0
13. I worry about sleeping alone.	0	0	0
14. I worry about being as good as other kids.	0	0	0
15. When I get frightened, I feel like things are not real.	0	0	0
16. I have nightmares about something bad happening to my parents.	0	0	0
17. I worry about going to school.	0	0	0
18. When I get frightened, my heart beats fast.	0	0	0
19. I get shaky.	0	0	0
20. I have nightmares about something bad happening to me.	0	0	0

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

	0 Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True
21. I worry about things working out for me.	0	0	0
22. When I get frightened, I sweat a lot.	0	0	0
23. I am a worrier.	0	0	0
24. I get really frightened for no reason at all.	0	0	0
25. I am afraid to be alone in the house.	0	0	0
26. It is hard for me to talk with people I don't know well.	0	0	0
27. When I get frightened, I feel like I am choking.	0	0	0
28. People tell me that I worry too much.	0	0	0
29. I don't like to be away from my family.	0	0	0
30. I am afraid of having anxiety (or panic) attacks.	0	0	0
31. I worry that something bad might happen to my parents.	0	0	0
32. I feel shy with people I don't know well.	0	0	0
33. I worry about what is going to happen in the future.	0	0	0
34. When I get frightened, I feel like throwing up.	0.	0	0
35. I worry about how well I do things.	0	0	0
36. I am scared to go to school.	0	0	0
37. I worry about things that have already happened.	0	0	0
38. When I get frightened, I feel dizzy.	0	0	0
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)	0	0	0
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	0	0	0
41. I am shy.	0	0	0

SCORING:

A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher that 30 are more specific.

A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatic Symptoms.

A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder.

A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder.

A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder.

A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance.

*For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

CMRS, PARENT VERSION

Date of Birth

Case # / ID #

Child's name

IN	(mm/de	d/yy)		, , ,		
Instructions						
ite	ne following questions concern your child's mood and behavior in the m. Please consider it a problem if it is causing trouble and is beyond ver' if the behavior is not causing trouble.	e past month . d what is nom	Please place a che nal for your child's	ck mark or an 'r age. Otherwise,	x' in a box for each , check 'rare or	
D_{i}	oes your child	Never/ Rarely	SOMETIMES	OFTEN	Very Often	
1.	Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world"	0		2	3	
2.	Feel irritable, cranky, or mad for hours or days at a time	()		2	3	
3.	Think that he or she can be anything or do anything (e.g., leader, best basket ball player, rap singer, millionaire, princess) beyond what is usual for that age	()		2	3	
4.	Believe that he or she has unrealistic abilities or powers that are unusual, and may try to act upon them, which causes trouble	()		. 2	3	
5.	Need less sleep than usual; yet does not feel tired the next day	()		-	3	
6.	Have periods of too much energy	0	1	2	3	
7.	Have periods when she or he talks too much or too loud or talks a mile-a-minute	()	I	2	3	
8.	Have periods of racing thoughts that his or her mind cannot slow down, and it seems that your child's mouth cannot keep up with his or her mind	()	1	2	3	
9.	Talk so fast that he or she jumps from topic to topic	()		2	3	
10.	Rush around doing things nonstop	()	I	2	3	
11.	Have trouble staying on track and is easily drawn to what is happening around him or her	()		2	3	
12.	Do many more things than usual, or is unusually productive or highly creative	()	1	7	3	
13.	Behave in a sexually inappropriate way (e.g., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually)	0	1	2	3	
14.	Go and talk to strangers inappropriately, is more	()		2	3	

Does your child	NEVER	SOMETIMES	OFTEN	Very Often	
15. Do things that are unusual for him or her that are foolish or risky (e.g., jumping off heights, ordering CDs with your credit cards, giving things away)	()	I	2	3	
16. Have rage attacks, intense and prolonged temper tantrums	0	1	2	3	
17. Crack jokes or pun more than usual, laugh loud, or act silly in a way that is out of the ordinary	0		2	3	_
18. Experience rapid mood swings	0	1	2	3	_
19. Have any suspicious or strange thoughts	0	1	2	.3	_
20. Hear voices that nobody else can hear	()	111	2	.3	
21. See things that nobody else can see	0		2	.3	_

TOTAL SCORE _

Please send comments to: Mpavuluri@psych.uic.edu

The SNAP-IV Teacher and Parent Rating Scale James M. Swanson, Ph.D., University of California, Irvine, CA 92715

Name:	Gender:	Age:	Grade: _		Date:			_
Ethnicity (circle one which best applies): African-A	merican A	sian Caucasian	Hispanic	Other:	8			
Completed By: Relationship to Patient:								
For each item, check the column which best descri	bes this child:				Not at All	Just a Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or m			ork or tasks					<u> </u>
 Often has difficulty sustaining attention in tasks Often does not seem to listen when spoken to d 	irectly							
4. Often does not follow through on instructions an5. Often has difficulty organizing tasks and activitie	:S							
6. Often avoids, dislikes, or reluctantly engages in7. Often loses things necessary for activities (e.g.,	tasks requiring	g sustained mental e	effort or books)					-
Often is distracted by extraneous stimuli Often is forgetful in daily activities	10 / 0 / 00 / 00 / 0	ooigranionto, ponosio	, 0, 20010)					
Often has difficulty maintaining alertness, orient	ing to request	s, or executing direc	tions					
11. Often fidgets with hands or feet or squirms in se	eat				·			
12. Often leaves seat in classroom or in other situa13. Often runs about or climbs excessively in situat	tions in which ions in which i	remaining seated is t is inappropriate	expected					
14. Often has difficulty playing or engaging in leisur 15. Often is "on the go" or often acts as if "driven by	e activities qu							
16. Often talks excessively								
17. Often blurts out answers before questions have18. Often has difficulty awaiting turn								
19. Often interrupts or intrudes on others (e.g., butt. 20. Often has difficulty sitting still, being quiet, or inl	s into convers	ations/games) es in the classroom	or at home					
21. Often loses temper			or acromo				Manage of the second se	
22. Often argues with adults								
23. Often actively defies or refuses adult requests of24. Often deliberately does things that annoy other	people							
25. Often blames others for his or her mistakes or n26. Often touchy or easily annoyed by others	nisbehavior							
27. Often is angry and resentful28. Often is spiteful or vindictive								
29. Often is quarrelsome								
30. Often is negative, defiant, disobedient, or hostile	e toward autho	ority figures						
31. Often makes noises (e.g., humming or odd sour32. Often is excitable, impulsive	nds)							
33. Often cries easily 34. Often is uncooperative								
35. Often acts "smart"								
36. Often is restless or overactive37. Often disturbs other children								
38. Often changes mood quickly and drastically39. Often easily frustrated if demands are not met in	nmediately							
40. Often teases other children and interferes with t								
41. Often is aggressive to other children (e.g., picks		es)						
42. Often is destructive with property of others (e.g. 43. Often is deceitful (e.g., steals, lies, forges, copie	s the work of	others, or "cons" oth	ers)					
44. Often and senously violates rules (e.g., is truant 45. Has persistent pattern of violating the basic right	, runs away, o	r completely ignores	s class rules)					
, , , , , , , , , , , , , , , , , , , ,		-yyy	-					

For each item, check the column which best describes this child:	Not at All	Just a Little	Quite A Bit	Very Much
46. Has episodes of failure to resist aggressive impulses (to assault others or to destroy property) 47. Has motor or verbal tics (sudden, rapid, recurrent, nonrhythmic motor or verbal activity) 48. Has repetitive motor behavior (e.g., hand waving, body rocking, or picking at skin) 49. Has obsessions (persistent and intrusive inappropriate ideas, thoughts, or impulses)				
50. Has compulsions (repetitive behaviors or mental acts to reduce anxiety or distress)				
51. Often is restless or seems keyed up or on edge 52. Often is easily fatigued				
53. Often has difficulty concentrating (mind goes blank)54. Often is irritable				
55. Often has muscle tension56. Often has excessive anxiety and worry (e.g., apprehensive expectation)				
57. Often has daytime sleepiness (unintended sleeping in inappropriate situations)				
58. Often has excessive emotionality and attention-seeking behavior	- A			
59. Often has need for undue admiration, grandiose behavior, or lack of empathy60. Often has instability in relationships with others, reactive mood, and impulsivity				
61. Sometimes for at least a week has inflated self-esteem or grandiosity				
62. Sometimes for at least a week is more talkative than usual or seems pressured to keep talking 63. Sometimes for at least a week has flight of ideas or says that thoughts are racing				
64. Sometimes for at least a week has elevated, expansive or euphoric mood65. Sometimes for at least a week is excessively involved in pleasurable but risky activities				
66. Sometimes for at least 2 weeks has depressed mood (sad, hopeless, discouraged)				
67. Sometimes for at least 2 weeks has irritable or cranky mood (not just when frustrated) 68. Sometimes for at least 2 weeks has markedly diminished interest or pleasure in most activities				
69. Sometimes for at least 2 weeks has psychomotor agitation (even when more active than usual) 70. Sometimes for at least 2 weeks has psychomotor retardation (slowed down in most activities)				
71. Sometimes for at least 2 weeks is fatigued or has loss of energy72. Sometimes for at least 2 weeks has feelings of worthlessness or excessive, inappropriate guilt				
73. Sometimes for at least 2 weeks has diminished ability to think or concentrate				
74. Chronic low self-esteem most of the time for at least a year75. Chronic poor concentration or difficulty making decisions most of the time for at least a year				
76. Chronic feelings of hopelessness most of the time for at least a year				
77. Currently is hypervigilant (overly watchful or alert) or has exaggerated startle response78. Currently is irritable, has anger outbursts, or has difficulty concentrating				
79. Currently has an emotional (e.g., nervous, worried, hopeless, tearful) response to stress 80. Currently has a behavioral (e.g., fighting, vandalism, truancy) response to stress				
81. Has difficulty getting started on classroom assignments				
82. Has difficulty staying on task for an entire classroom period83. Has problems in completion of work on classroom assignments				
84. Has problems in accuracy or neatness of written work in the classroom85. Has difficulty attending to a group classroom activity or discussion				
86. Has difficulty making transitions to the next topic or classroom period 87. Has problems in interactions with peers in the classroom				
88. Has problems in interactions with staff (teacher or aide) 89. Has difficulty remaining quiet according to classroom rules				
90. Has difficulty staying seated according to classroom rules				



Medication Profile

Please list any medications that are currently being prescribed to you.

	Name of Medication	Dosage	Prescribing Physician	Last Date Filled
			_	
		-		
34444444444444444444444444444444444444				
				,
			·	

EXPRESS AND INFORMED CONSENT FOR TREATMENT

PATIENT NAME:	
I the undersigned, apatient,guard hereby authorize the professional staff of and treatment.	lian advocate, healthcare surrogate/proxy, this facility to administer mental health assessment
I understand that I am responsible for fees	s for services rendered.
I understand that more information will be be requested for the administration of psy	e provided to me before my informed consent will vchotropic medications.
I understand that my consent can be revol treatment period.	ked orally or in writing prior to, or during the
Center agrees not release any information on a need to know basis without getting you protects such information. Violations of the However, there are times when the law also include cases where there is physical and so disabled persons; there is expression of interesting the commission of a crime on Serenity Health or requiring Serenity Health Center to release	tial, but there are some exceptions. Serenity Health about you, other than Serenity Health Center staff our permission in writing. Florida and Federal law nese regulations may be reported as a crime. So says that information must be shared. These sexual abuse or neglect of children, elders, or tent to harm self or others; there is a threat or Center's premises or to staff; a court order is issued a information; we learn of a contagious disease equires that we report client data for follow-up
herebyGIVEDO NOT GIVE Serenity H	ealth Center permission to contact me.
	appointment or to find out how you are doing upon () during these times:
Signature of Patient:	Date:
signature of Parent or Guardian:	Date:
Signature of Witness	Date:

Patient Rights And Responsibilities

While receiving services from Serenity Health Center you have the right to....

- 1. An environment that preserves the dignity and contributes to a positive self-image.
- 2. Be served in the least restrictive treatment alternative available with your treatment needs.
- 3. Have all identifying and treatment information held in a confidential manner.
- 4. Know that information disclosed concerning abuse, neglect or exploitation of a child, disabled adult, or the elderly MUST be reported to the Department of Health and Rehabilitation for possible investigation (under Florida State Law).
- 5. Be involved in the development and review the clinical records compiled as a result of treatment.
- 6. Refuse care, treatment or services at any time.
- 7. Treatment free from mental, physical sexual and verbal abuse, neglect and exploitation, or any form of corporal punishment.
- 8. To be informed (and when appropriate, family members) about the outcomes of care, including unanticipated outcomes.
- 9. Exercise citizenship privileges.

As a patient of Serenity Health Center you have the responsibility to ...

- 1. Provide accurate and complete information.
- 2. Schedule appointments and make any calls during normal office hours 9 am-4 pm Mon-Wed.

 If you call after normal business hours please leave a message and we will return your call. If you are in crisis or have an emergency immediately call 911.
- 3. Meet financial commitments by: A) Paying the fees for services rendered.
 - B) Being financially responsible for missed appointments.
- 4. Ask questions when you do not understand your care or do not know what is expected of you.
- 5. Show respect and consideration. You may be held legally responsible for any verbal or physical abuse towards Serenity Health Center's staff.
- 6. Follow rules and regulations set forth by staff.

Witness Signature

- 7. Attend medication appointments to obtain prescription refills.
- 8. Accept the consequences for outcomes if you do not follow treatment recommendations.

By signing this form, I am verifying that I have read and re	eceived a copy of my Rights and Responsibilities form.
Patient Signature:	Date
Parent or Guardian Signature:	Date

Date

Serenity Health Center NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions regarding this notice, please contact

Serenity Health Center 835 Oakley Seaver Dr.

Clermont, FL 34711 Effective date November 14, 2008

WHO WILL FOLLOW THIS NOTICE

This notice describes our practice's privacy practices and that of:

Any physician or health care professional authorized to enter information into your medical chart. All departments and units of the practice.

All employees, staff and other personnel.

All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with third party specialists for treatment, payment, or office operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

make sure that medical information that identifies you is kept private;

give you this notice of our legal duties and privacy practices with respect to medical information about you, and

follow the terms of this notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be used. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you in the office and elsewhere. We also may disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care provided you have consented to such disclosure. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the

For Healthcare Operation. We may use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective, We may also disclose information to our physicians, staff and other office personnel for review and learning purposes.

Appointment Reminders. We may also use your information to contact you as a reminder that you have an appointment for treatment or medical care in the office. You may be contacted by any of our personnel via phone. mail or email.

phone, mail or email.

Treatment Alternatives. We may use your information to tell you about possible recommended treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use your information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified of your condition status and location. notified of your condition, status and location.

As Required By Law. We will disclose medical information about you when required to do so by federal,

state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court order, a subpoena, warrant, summons or similar process. To identify or locate a suspect, fugitive, material witness or missing person, about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement, about a death we believe may be the result of criminal conduct, about at the office, and emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners. Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to carry out their

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we obtain about you:

Right to Inspect and Copy. You have a right to a copy of your medical information that may be used to make decisions about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Serenity Health Center. If you request a copy of the information, we may charge a fee for the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.

Right to Amend. If you feel that information we have about you is incomplete or incorrect, you may ask us to amend the information. You have the right to ask for an amendment for as long as the information is kept by our office. To request an amendment, you must request in writing to your physician. In addition you must provide a reason that supports your request. We may refuse to amend your record under certain limited circumstances.

Right to an Accounting of Disclosures. You have a right to request a list of disclosures we made of medical information about you. To request this list you must submit a request in writing to Serenity Health Center and denote a time period not to exceed seven years, or to predate November 14, 2008. The first request is free of charge but additional lists we may apply fees to be determined before any charges are applied, at which time you may retract your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use to disclose about you for treatment, payment or healthcare operations. You also have a right to request a limit on the medical information we disclose about you to someone who is involved in you care or payment for your care, like

a family member or friend.

We are not required to agree to your request. If we do agree to comply with your request, we will do so unless the information is needed to provide you emergency treatment. You must submit a request in writing to Serenity Health Center citing (1) which information you wish to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we only contact you at wok or by mail. Please submit your request in writing. We will not ask a reason for your request and we will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have a right to receive a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may request in writing to Serenity Health Center that a copy be mailed to you.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have or may obtain in the future. We will post a current copy of the notice in the office. The notice will contain on the first page, in the top left hand corner, the effective date. In addition, each time you register we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with Serenity Health Center, 835 Oakley Seaver Drive, Clermont, Florida 34711 or with the Office of Civil Rights within the Department of Health and Human Services by visiting their website at www.hhs.gov/ocr/hipaa. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission, you may also revoke that permission at any time, in writing. If you revoke your permission, we will no longer use or disclose information about you for reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Notice of Privacy Practices Acknowledgement and Consent

The notice of Privacy Practices tells you how we may use and share your health records.

- 1. We will use and share your health records to treat you and to bill for the services we provide.
- 2. We will use and share your health records to run our practice.
- 3. We will use and share your health records as required by law.

You have the following rights with respect to your health records:

- 1. You have the right to look at and receive a copy of your records.
- 2. You have the right to receive a list of whom we have given your records to.
- 3. You have the right to ask us to correct a mistake in your heath records.
- 4. You have the right to ask that we not use or share your health records.
- 5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices

I have received a copy of Serenity Health Center's Notice of Privacy Practices.

I **consent** to the use and the sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Signature:			
(Patient	or	Legal	Representative)
Date:			

Serenity Health Center 835 Oakley Seaver Drive

Clermont, FL 34711

You Must Read And Initial Where Indicated

 3. 4. 	I request that payment of authorized Medicare/Other Insurance Company benefits be made on behalf to Serenity Health Center for services rendered from physicians or associates of Serenity Health Center. () Initials I authorize Serenity Health Center to release any medical information concerning me to my insurance company or its agents necessary to determine benefits or the benefits related to the payable services. I am aware that I am responsible for any deductibles, co-insurances, and noncovered services. I understand this applies to all Medicare, and Commercial Insurance Companies. () Initials I understand that payment is due at the time services are rendered. All co-pays and deductibles will be collected. () Initials Serenity Health Center will file a claim to your insurance company. If your insurance company does not respond to the claim within 60 days from the date of filing, then the balance will become the Patient's responsibility. The patient will receive a statement and payment is due upon receipt. If payment is not received within 30 days further action will be taken. If your deductible has not been met, or if you do not have insurance, arrangements must be made prior to seeing the M.D. () Initials Medicare Patients: We will file your secondary insurance as a courtesy. We will only bill one insurance company after Medicare. If we receive no response, the balance after Medicare pays is your responsibility.
6.	()Initials If you have an HMO, obtaining authorization is your responsibility for all visits, procedures, etc. If you choose to be seen without an authorization and your insurance denies payment, you will be responsible for the entire bill. () Initials
m	portant Note: Please remember that your coverage is a contract between
you	and your insurance company. WE ARE NOT PART OF THAT CONTRACT.
We	e file as a courtesy to you.
, _	(Print Name) have read and understand the above billing
anc	insurance procedures.
Pat	ient Signature Date

NO SHOW/NO CONTACT OFFICE POLICY

Appointments are scheduled to accommodate your schedule and the doctors' schedule.

- Patients must Arrive by the of their scheduled appointment
- Patients have 15min extra to arrive after their appointment time if they are running late, and need to arrive within that time.
- If patient is running late, they are required to place a courtesy call to the
 office to make us aware to be able to accommodate the patient when he/she
 arrives.
- If patient arrives after their appointment time and no courtesy call was placed they will be charged a No Show/No Contact Fee of \$100.00.
- Appointment Reminder calls are placed as a courtesy to all patients.
- Patients/parents are requested to contact the office to confirm the appointment.
- If an appointment is not confirmed/cancelled or rescheduled within 24-48 hours the patient will be charged a No Show/No Contact Fee of \$100.00.

Patient Name	
Patient Signature	Date
Parent/Legal Guardian Signature	Date