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: _____
No Street Apt # City State Zip

Telephone No: _____ Cell No: _____

SS No: _____ Sex: M F Date of Birth: ___/___/_____ Race: _____

Email: _____ **Allergies:** _____

Social Status Child is: Still at Home School Working

Child's place of Education: _____
Name Address City

Child's place of Employment: _____
Name Address City

Who referred you to this office? _____
Name Telephone #

Who is child's Pediatrician? _____
Name Telephone#

For what problem(s) with your child do you seek help? _____.

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 will help? _____

_____.

What form of treatment do you expect for your child (psychotherapy, medication, other)? _____.

How long do you think this will take? _____.

Parent(s)/Legal Guardian/Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Employer_____ Work Phone (____) _____ SSN#_____

Billing/Insurance Information

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 SECONDARY 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 # _____ DATE: _ _ / _ _ / _ _
(For office use only.)

PARENT-REPORT QUESTIONNAIRE

DEMOGRAPHICS:

Child's Name (last, first, mi) _____

Address_____

City_____ State_____ Zip Code_____

Phone Number: home (_____)_____ work (_____)_____

Person Completing this form: _____Relationship to child:____

Sex: M F Date of birth: _ _ / _ _ / _ _ Age at admission: _ _ years _ _ months
mm dd yy

Race: __
1=White
2=African-American
3=Hispanic
4=Asian
5=Native-American
6=Pacific Islander
0=Other_____

Religion: __
1=Catholic
2=Protestant
3=Jewish
4=Agnostic
0=Other_____

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 household as the child?:

NAME	SEX	AGE	RELATIONSHIP TO CHILD

revised 9/29/94

PATIENT NAME:_____MR # _____

Father's highest education received:____ Mother's highest education received:____

1=less than 7 years of schooling
2=junior high school
3=partial high school
4=high school graduate
5=technical school
6=partial college
7=college graduate
8=professional degree

Father's Current Occupation:____ Mother's Current Occupation:____

1=Executive, Professional
2=Manager/Lesser Professional
3=Administrator/Minor Professional
4=Clerical/Sales
5=Skilled
6=Semi-skilled
7=Unskilled
8=Student
9=Never worked
Why? _____

Father's perferred hand: _____ Mother'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 yes, which grade and why? _____

DEVELOPMENTAL HISTORY: (Not all parents remember the answers to these questions. You can write down what you do remember 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 pregnancy? Yes No If yes, what ? _____
   _____
3. Were forceps used at delivery? Yes No Not sure Don't Know
4. Any other complications of delivery?
   _____ Premature rupture of membrane _____ 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 baby cry? Yes No Not sure Don't Know

PATIENT NAME:_____MR # _____

8. Were there any problems with the baby after s/he was born?

_____ Incubator
_____ Blueness or trouble breathing
_____ Hyaline membrane disease
_____ Other: _____
_____ Jaundice
_____ Convulsions
_____ Trouble feeding (breast or bottle)

9. When did the baby leave the hospital? _____

10. When the baby came home, were there any problems?

_____ Colic, excessive irritability or crying
_____ Sleepiness, too quiet, lethargy
_____ Poor feeding
_____ Slept too little
_____ Too floppy
_____ Too stiff

11. When did the baby really smile (not "gas")? _____

12. When was the baby able to sit by him/herself WITHOUT PROPPING OR HELP? _

13. When did the baby start to walk by him/herself WITHOUT HOLDING ON? _____

14. When did the baby say his/her first word? _____

15. When did the baby say short sentences like: "I want milk" 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 1 year after 2 years after 4 years

20. Anything else significant occur during the child's development years? _____

_____

_____

PATIENT NAME:_____MR # _____

MEDICAL HISTORY:

Does your child have any history of the following:

Illness	No	Yes	At what Age(s)?	✓ if still present	Comments
Allergies (describe)					
Asthma					
Chicken Pox					
Complications at Birth					
Convulsions, Seizures, Epilepsy					
Dizziness or Fainting					
Head Injury					
High Blood Pressure					
Loss of Consciousness					
Low Blood Pressure					
Measles					
Other Serious Illness: _____					
Other Serious Illness: _____					
Respiratory Illness					
Rheumatic Fever					
Sleep Problems					
Urogenital Problems					
Vision Problems (e.g. Lazy eye)					

MEDICAL PROCEDURES:

Has your child ever had surgery (an operation)?

No Yes If yes, describe and give dates below:

Type	Date	Comments

PATIENT NAME:_____MR # _____

Has your child ever had any serious injuries?

No Yes If yes, describe and give dates below:

Type	Date	Comments

Is your child currently taking any medication?

No Yes If yes, please list:

Name	Dose	Date Started	Reason

Girls only *(circle appropriate number and describe):*

Has your daughter had her 1st period? No Yes

If Yes, age_____

Are periods regular? No Yes

Date of last menstrual period _____

Is there any change in symptom severity with periods? No Yes

If Yes, please describe_____

_____

Is there any possibility that your daughter is pregnant? No Yes

NEUROPSYCHIATRIC HISTORY:

Has your child ever:

1. made involuntary body movements or sounds (tics)? No Yes

   Age of first tic(s): _ _ years *please describe:*_____

   _____

   _____

   _____

2. had recurrent disturbing thoughts or worries (obsessions)? No Yes

   Age of 1st obsessions: _ _ years *please describe:*_____

   _____

   _____

   _____

PATIENT NAME:_____ MR # _____

3. had repetitive or excessive habits (compulsions)? No Yes
   Age of 1st compulsions: _ _ years *please describe:*_____

4. had problems with attention, concentration, hyperactivity? No Yes
   Age of 1st symptoms: _ _ years *please describe:*_____

5. been diagnosed with a learning disability? No Yes
   Age of 1st symptoms: _ _ years *please describe:*_____

6. had other emotional or behavioral problems? No Yes
   Age of 1st symptoms: _ _ years *please describe:*_____

Have you ever sought professional treatment for your child for any of the above problems?
No Yes If yes, give details below:

Problem (Diagnosis)	Start Date	Stop Date	Type (see scale below)	Inpatient, Outpatient, or Day Hospital?	Benefit (scale at bottom of page)

THERAPY TYPE SCALE

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

Benefit Rating Scale:
Good, Fair, Poor

PATIENT NAME:_____MR # _____

MEDICATION HISTORY

Has your child ever been treated for emotional or psychiatric problems with medication?
No Yes

If yes, please complete information in the table below:

MEDICATIONS	No	Yes	Dose	Start Date	Stop Date	Diagnosis	Benefit (scale below)	Side Effects
ANTI-DEPRESSANTS								
Amitriptyline (Elavil)								
Bupropion (Wellbutrin)								
Clomipramine (Anafranil)								
Desipramine (Norpramin)								
Fluoxetine (Prozac)								
Fluvoxamine (Favaran)								
Imipramine (Tofranil)								
Nortriptyline (Pamelor)								
Paroxetine (Paxil)								
Sertraline (Zoloft)								
Other:								
ANTIANXIETY/ SLEEP DRUGS								
Buspirone (Buspar)								
Clonazepam (Klonopin)								
Lorazepam (Ativan)								
Other:								
ANTI-PARKINSONIAN								
Benztropine (Cogentin)								
Diphenhydramine (Benadryl)								
Other:								

Benefit Rating Scale:
Good, Fair, Poor

PATIENT NAME:_____MR # _____

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

Benefit Rating Scale:
Good, Fair, Poor

PATIENT NAME:_____MR # _____

FAMILY HISTORY

Is your child adopted? No Yes

Have any of the child's blood relatives had a serious emotional, behavioral or neurological problem? (For example, hyperactivity, learning disability, abnormal movements)

No Yes

If yes, fill in table below:

Name (or initials)	Age	Relationship	Father's Side	Mother's Side	Suspected Diagnosis	Received Therapy?

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 Age	Duration
	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		
	8.	Sexual abuse		
	9.	Parent with substance abuse problem		
	10.	Conflicts with parents		
	11.	Removal of child from home		
	12.	Victim of crime or violence		n/a
	13.	Unwanted pregnancy		n/a
	14.	School problems		
	15.	Illness in self		
	16.	Illness in family (specify_____)		
	17.	Other_____		

For office use:

Reviewed by _____ *Date reviewed* _____

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-American Asian Caucasian Hispanic Other: _____

Completed By: _____ Relationship to Patient: _____

For each item, check the column which best describes this child:	Not at All	Just a Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
8. Often is distracted by extraneous stimuli				
9. Often is forgetful in daily activities				
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions				
11. Often fidgets with hands or feet or squirms in seat				
12. Often leaves seat in classroom or in other situations in which remaining seated is expected				
13. Often runs about or climbs excessively in situations in which it is inappropriate				
14. Often has difficulty playing or engaging in leisure activities quietly				
15. Often is "on the go" or often acts as if "driven by a motor"				
16. Often talks excessively				
17. Often blurts out answers before questions have been completed				
18. Often has difficulty awaiting turn				
19. Often interrupts or intrudes on others (e.g., butts into conversations/games)				
20. Often has difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home				
21. Often loses temper				
22. Often argues with adults				
23. Often actively defies or refuses adult requests or rules				
24. Often deliberately does things that annoy other people				
25. Often blames others for his or her mistakes or misbehavior				
26. Often touchy or easily annoyed by others				
27. Often is angry and resentful				
28. Often is spiteful or vindictive				
29. Often is quarrelsome				
30. Often is negative, defiant, disobedient, or hostile toward authority figures				
31. Often makes noises (e.g., humming or odd sounds)				
32. Often is excitable, impulsive				
33. Often cries easily				
34. Often is uncooperative				
35. Often acts "smart"				
36. Often is restless or overactive				
37. Often disturbs other children				
38. Often changes mood quickly and drastically				
39. Often easily frustrated if demands are not met immediately				
40. Often teases other children and interferes with their activities				
41. Often is aggressive to other children (e.g., picks fights or bullies)				
42. Often is destructive with property of others (e.g., vandalism)				
43. Often is deceitful (e.g., steals, lies, forges, copies the work of others, or "cons" others)				
44. Often and seriously violates rules (e.g., is truant, runs away, or completely ignores class rules)				
45. Has persistent pattern of violating the basic rights of others or major societal norms				

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 tension				
56. 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				
59. Often has need for undue admiration, grandiose behavior, or lack of empathy				
60. 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 mood				
65. 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 energy				
72. 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 year				
75. 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 response				
78. 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 period				
83. Has problems in completion of work on classroom assignments				
84. Has problems in accuracy or neatness of written work in the classroom				
85. 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				

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

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	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worrier.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard for my child to talk with people he/she doesn't know well.	○	○	○
27. When my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
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.)	○	○	○
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.	○	○	○
41. My child is shy.	○	○	○

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

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

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	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	○	○	○
22. When I get frightened, I sweat a lot.	○	○	○
23. I am a worrier.	○	○	○
24. I get really frightened for no reason at all.	○	○	○
25. I am afraid to be alone in the house.	○	○	○
26. It is hard for me to talk with people I don't know well.	○	○	○
27. When I get frightened, I feel like I am choking.	○	○	○
28. People tell me that I worry too much.	○	○	○
29. I don't like to be away from my family.	○	○	○
30. I am afraid of having anxiety (or panic) attacks.	○	○	○
31. I worry that something bad might happen to my parents.	○	○	○
32. I feel shy with people I don't know well.	○	○	○
33. I worry about what is going to happen in the future.	○	○	○
34. When I get frightened, I feel like throwing up.	○	○	○
35. I worry about how well I do things.	○	○	○
36. I am scared to go to school.	○	○	○
37. I worry about things that have already happened.	○	○	○
38. When I get frightened, I feel dizzy.	○	○	○
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.)	○	○	○
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.	○	○	○
41. I am shy.	○	○	○

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

CHILDREN'S DEPRESSION INVENTORY

CDI

NAME: _____ DATE: _____

Kids sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group, pick one sentence that describes you best for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right answer or wrong answer. Just pick the sentence that best describes the way you have been recently.

Fill in the circle ☞ O next to the sentence that you pick for your answer.

Here is an example of how this form works. Try it. Fill in the circle next to the sentence that describes 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 the 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)

Version:
7/77 with format changes 8/79 and 3/92

CHILD NAME: _____
DATE: _____

YMRS – PARENT VERSION

Directions: Please read each question below and circle the answer number which most closely describes your child.

1. **Mood** – *Is your child's mood higher (better) than usual?*

   0. No
   1. Mildly or possibly increased
   2. Definite elevation – more optimistic, self-confident; cheerful; appropriate to their conversation.
   3. Elevated but inappropriate to content; joking, mildly silly
   4. Euphoric; inappropriate laughter; singing/making noises; very silly

2. **Motor Activity/Energy** – *Does your child's energy level or motor activity appear to be greater than usual?*

   0. No
   1. Mildly or possibly increased
   2. More animated; increased gesturing
   3. Energy is excessive; hyperactive at times; restless but can be calmed
   4. Very excited; continuous hyperactivity, cannot be calmed

3. **Sexual Interest** – *Is your child showing more than usual interest in sexual matters?*

   0. No
   1. Mildly or possibly increased
   2. Definite increase when the topic arises
   3. Talks spontaneously about sexual matters; gives more detail than usual, more interested in girls/boys than usual
   4. Has shown open sexual behavior – touching others or self inappropriately

4. **Sleep** – *Has your child's sleep decreased lately?*

   0. No
   1. Sleeping less than normal amount by up to one hour
   2. Sleeping less than normal amount by more than one hour
   3. Need for sleep appears decreased; less than four hours
   4. Denies need for sleep; has stayed up one night or more

5. **Irritability** – *Has your child appeared irritable?*

   0. No more than usual
   2. More grouchy or crabby
   4. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
   6. Frequently irritable to point of being rude or withdrawn
   8. Hostile and uncooperative about all the time

6. **Speech (rate and amount)** – *Is your child talking more quickly or more than usual*

   0. No more than usual
   2. Seems more talkative
   4. Talking faster or more to say at times
   6. Talking more or faster to point he/she is difficult to interrupt
   8. Continuous speech; unable to interrupt

CHILD NAME: _____
DATE: _____

YMRS – PARENT VERSION – continued.

7. **Thoughts** – *Has your child shown changes in his/her thought patterns?*

0. No
1. Thinking Faster; some decrease in concentration; talking "around the issue"
2. Distractible; loses track of the point; changes topics frequently; thoughts racing
3. difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
4. Not understandable; he/she doesn't seem to make any sense

8. **Content** – *Is your child talking about different things than usual?*

0. No
2. He/she has new interests and is making more plans
4. Making special projects; more religious or interested in God
6. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
8. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs

9. **Disruptive-Aggressive Behavior** – *Has your child been more disruptive or aggressive?*

0. No; he/she is cooperative
2. Sarcastic; loud; defensive
4. More demanding; making threats
6. Has threatened a family member or teacher; shouting; knocking over possessions/furniture or hitting a wall
8. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without Violence

10. **Appearance** – *Has your child's interest in his/her appearance changed recently?*

0. No
1. A little less or more interest in grooming than usual
2. Doesn't care about washing or changing clothes, or is changing clothes more than three times a day
3. Very messy; needs to be supervised to finish dressing; applying makeup in overly-done or poor fashion
4. Refuses to dress appropriately; wearing bizarre styles

11. **Insight** – *Does your child think he/she needs help at this time?*

0. Yes; admits difficulties and wants treatment
1. Believes there might be something wrong
2. Admits to change in behavior but denies he/she needs help
3. Admits behavior might have changed but denies need for help
4. Denies there have been any changes in his/her behavior/thinking

Signature of Parent / Guardian: _____

EXPRESS AND INFORMED CONSENT FOR TREATMENT

PATIENT NAME:_____

I the undersigned, a ___patient, ___guardian advocate, ___ healthcare surrogate/proxy, hereby authorize the professional staff of this facility to administer mental health assessment and treatment.

I understand that I am responsible for fees for services rendered.

I understand that more information will be provided to me before my informed consent will be requested for the administration of psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I understand that my records are confidential, but there are some exceptions. Serenity Health Center agrees not release any information about you, other than Serenity Health Center staff on a need to know basis without getting your permission in writing. Florida and Federal law protects such information. Violations of these regulations may be reported as a crime. However, there are times when the law also says that information must be shared. These include cases where there is physical and sexual abuse or neglect of children, elders, or disabled persons; there is expression of intent to harm self or others; there is a threat or commission of a crime on Serenity Health Center's premises or to staff; a court order is issued requiring Serenity Health Center to release information; we learn of a contagious disease which may harm others; and or the State requires that we report client data for follow-up study.

I hereby_____GIVE_____DO NOT GIVE Serenity Health Center permission to contact me.

(We may want to contact you to remind you of an appointment or to find out how you are doing upon completion of your treatment.)You can call me at (_____) ____-_____ during these times: _____

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Witness _____ Date: _____

Serenity Health Center, PA

835 Oakley Seaver Drive
Clermont, FL 34711

You Must Read And Initial Where Indicated

1. I request that payment of authorized Medicare/Other Insurance Company benefits be made on behalf to Serenity Health Center, PA for services rendered from physicians or associates of Serenity Health Center, PA. (____) **Initials**

2. I authorize Serenity Health Center, PA to release any medical information 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 non- covered services. I understand this applies to all Medicare, and Commercial Insurance Companies. (____) **Initials**

3. I understand that payment is due at the time services are rendered. All co-pays and deductibles will be collected. (____) **Initials**

4. Serenity Health Center, PA will file a claim to my insurance company. If my insurance company does not respond to the claim within 60 days from the date of filing, then the balance will become my responsibility. I will receive a statement and payment is due upon receipt. If payment is not received within 30 days further action will be taken. If my deductible has not been met, or if I do not have insurance, arrangements must be made prior to seeing the Doctor.(____) **Initials**

5. **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. (____)**Initials**

6. **HMO Patients:** 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**

Important Note: Please remember that your coverage is a contract between you and your insurance company. We are not part of that contract. We file as a courtesy to you.

I, _____ have read and understand the above billing and insurance procedures.
(Financial Person Responsible for Payments)

_____
(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.
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 received a copy of my Rights and Responsibilities form.

Patient Signature: _____ Date _____

Parent or Guardian Signature: _____ Date _____

Witness Signature _____ 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 treatment.
- **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.
- **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.
- **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 civil rights laws.
- **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 criminal conduct 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 duties.

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 toSerenity 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: _____

Medication Profile

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

Name of Medication	Dosage	Prescribing Physician	Last Date Filled

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.**
- **Please be aware 3 NO SHOW'S will automatically result in a discharge from the practice.**

PLEASE BE AWARE WE WILL NOT BE RESPONSIBLE FOR ANY ADVERSE REACTIONS DUE TO DISCONTINUATION OF MEDICINE, DUE TO INABILITY TO COME TO YOUR SCHEDULED APPPOINTMENT AS DETERMINED BY PROVIDER. _____(INITIAL)

_____
Patient Name

_____ _____
Patient Signature **Date**

_____ _____
Parent/Legal Guardian Signature **Date**

Serenity Health Center, PA

835 Oakley Seaver Drive
Clermont, FL 34711-1968
Tel. 352-241-9282 Fax 352-241-4282

Patient Authorization Disclosure of Confidential Information

I, _____
(Please Print) If you are the legal guardian or parent.

for _____ Date of Birth_____
(Please print the child's name)

by signing this authorization form; authorize the use and disclosure of my health information in the manner described below.

I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of the health information.

I authorize, check all which are appropriate to be used and disclosed.

__ Diagnosis with Medication(s) Prescribed

__ Laboratory Results

__ Outpatient Treatment / Visits

__ Psychiatric Treatment & Services

__ Evaluation Results

__ Other

Please complete a form for **EACH** physician you visit.

I Authorize Serenity Health Center, PA **To Obtain** My Health Information From:
(List any person, practice, business, school etc. with whom Serenity Health Center,PA may communicate with.)

Name: _____ Tel:_____

Address: _____ Fax _____

I Authorize Serenity Health Center, PA **To Release** My Health Information To:
(List person(s), practice(s), employer(s), school etc. which Serenity Health Center, PA may send, give or communicate to.

Name: _____ Tel: _____

Address: _____

_____
Patient or Guardian Signature Date

_____
Witness Signature Date

Expiration Of Authorization: This authorization will expire 365 days from the date of this signing.