

CHILD PATIENT INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Referred by \_\_\_\_\_

Sex: M F Social Security Number \_\_\_\_\_

Mother's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Father's Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

FOR MINORS PLEASE INDICATE THE PARENT TO WHOM BILLS SHOULD BE ADDRESSED

Billing Party's Name \_\_\_\_\_ DOB \_\_\_\_\_

Billing Party's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work \_\_\_\_\_

Marital Status: S M D W Sex: M F Social Security Number \_\_\_\_\_

Place of Employment \_\_\_\_\_ How Long? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Referred by \_\_\_\_\_

Name and Address of Non-Custodial Parent (if any) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ Place of Employment \_\_\_\_\_

INSURANCE

Primary Insurance Company \_\_\_\_\_ Subscriber Employer \_\_\_\_\_

Contract Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Subscriber Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**\*\*Please note\*\* whomever brings a child in to be seen is responsible for payment at the time of service. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent. The legal guardian must accompany a minor child.**

Insurance Authorization and Assignment

I understand that I am financially responsible for any medical service at the time of the service. I authorize my insurance carrier to pay Valley Psychiatric Associates, P.C. any assigned claims filed by them and authorize for release of medical information requested by my insurance company.

Date \_\_\_\_\_ Signature \_\_\_\_\_

I have received the Privacy Notice. Date \_\_\_\_\_ Initial \_\_\_\_\_

# VALLEY *PSYCHIATRIC ASSOCIATES, P.C.*

## AUTHORIZATION FOR CORRESPONDENCE

I hereby authorize Valley Psychiatric Associates to contact me for purposes of scheduling, rescheduling, verifying appointment, or for any other reason affecting my treatment.

You may:

send mail to my home

call me at home at phone number: \_\_\_\_\_

leave a message on my answering machine

leave a message with whomever answers the above telephone number

call me at work, but speak only with me at phone number: \_\_\_\_\_

call my cell phone at phone number: \_\_\_\_\_

leave a message on my cell phone voicemail (if applicable)

I give Valley Psychiatric Associates permission to contact my:

Primary Care Physician       Yes\*    No

Psychiatrist/Other Therapist       Yes\*    No

School/Employer       Yes\*    No

\*Please complete the appropriate Release of Information form.

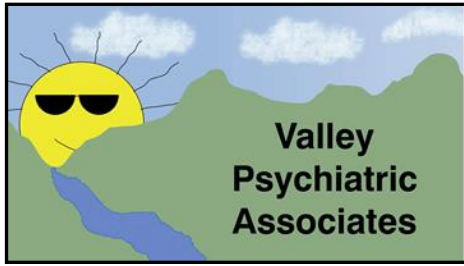
**I have read the above authorization and understand the same.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date/Time



*Child, Adolescent, and Family Psychiatry*

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## **CONFIDENTIALITY STATEMENT**

### **For Patients, Visitors, Guest**

**As a patient, visitor, or guest at Valley Psychiatric Associates, I understand that Federal Regulations on Confidentiality require that I not reveal the identity of any person I may see or the identity of any person's record that I may see while at the office.**

**I understand that any disclosure of patient information, including the person's presence in treatment, or any description of any person, without specific written consent from that person may be interpreted as a Federal Criminal Offense.**

**I agree to maintain patient's confidentiality.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

**PATIENT CONTRACT**

Our staff attempts to provide the best services possible. All services are directed by a psychiatrist, board certified in child and adolescent psychiatry as well as general adult psychiatry. Our staff works hard to maintain professional skills through regular continuing education courses. However, we can only provide the best possible service when we work together with you. In order to help you understand your role, this contract sets out office guidelines.

Co-pays and deductibles are due at the time of service. You will be responsible for whatever the insurance does not pay.

**\*\*Please note\*\* whomever brings a child in to be seen is responsible for payment at the time of service. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent. The legal guardian must accompany a minor child.** Please do not bring younger siblings to appointments, if possible.

Insurance companies vary their requirements. It is **your** responsibility to check with the insurance company regarding benefits. If you need assistance dealing with your insurance company, this office will be available.

Outstanding accounts that cannot be collected through this office will be turned over to a collection agency after 90 days delinquency. **ALL COST** incurred to collect debt will be added to the account balance, including attorney fees.

Our providers see patients for treatment purposes only. Requests for testimony in any court require a separate VPA Forensic Contract.

You will be charged for missed appointments or appointments cancelled less than 24 hours before your appointment. This charge is not reimbursed by any insurance company. Treatment is only successful when you attend all appointments. If an emergency occurs call the office as soon as possible. Please do not come if you are sick (fever greater than 100, vomiting more than once, persistent diarrhea) as this simply spreads it to everyone, including us. Call as soon as you can when you are sick so that we can reschedule.

If **Madison City Schools** are closed for bad weather, then our office will close. **IF SCHOOLS ARE ONLY DELAYED DUE TO WEATHER, APPOINTMENTS WILL BE KEPT AS SCHEDULED.**

You are responsible for your medications. Bring the bottles when you see the physician. If you need a refill you must give 5 working days notice before you are out of medication. There is a \$10.00 charge for any prescription requested with less than 5 days notice.

There will be charges **up to \$45.00 for forms** to be filled out by this office. Example: FMLA or student accommodation forms, or Prior Authorizations.

Patients receiving medications from VPA medical staff are expected to be actively involved with a VPA therapist. Receiving scheduled prescription medications from a VPA provider and another provider will result in your case being closed.

Missing any three (3) appointments (physician, individual, family, or group) will be demonstration of your unwillingness to cooperate with treatment and grounds for immediate termination of services through this office. You will be notified by mail. There will be a **\$45.00** fee for **each** missed appointment prior to termination.

It is your responsibility to let us know if there is a problem with the services you receive. You should discuss any problems with the office manager, therapist, or physician. We can't fix what we don't know.

In the event of an emergency outside of office hours call 911 or go to the nearest emergency room.

**I have read and understand this contract. I agree to abide this contract while receiving services.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Print Name of Guardian

Valley Psychiatric Associates, P.C.

We want to learn things about your child's life. The following questions will aid us in gathering information and allow you to look up important events and remember important details you may wish to discuss with the doctor.

**EARLY DEVELOPMENT**

Were there any problems with your pregnancy with this child? \_\_\_\_\_

How much did either parent smoke, drink alcohol, or use drugs before, during, or after pregnancy?

MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

Was your child born on time? \_\_\_\_\_ Were there any problems at the time of delivery? \_\_\_\_\_

\_\_\_\_\_ Jaundice (yellow skin) \_\_\_\_\_ Need I.V. or Antibiotics \_\_\_\_\_ Breathing Problems

\_\_\_\_\_ Need Special Care Nursery \_\_\_\_\_ Other \_\_\_\_\_

As an infant, was your child \_\_\_\_\_ Sickly \_\_\_\_\_ Colicky \_\_\_\_\_ Poor Sleeper \_\_\_\_\_ Feeding Problems \_\_\_\_\_ Easy Baby to Care For

At what age did your baby? \_\_\_\_\_ Sit Up \_\_\_\_\_ Walk \_\_\_\_\_ Toilet Trained

At what age did you regularly leave your child with another caretaker? \_\_\_\_\_

**EDUCATION**

What was your child's first school experience? \_\_\_\_\_ Head Start \_\_\_\_\_ Pre-School \_\_\_\_\_ Kindergarten \_\_\_\_\_ Other

What grade is your child in? \_\_\_\_\_ Any problems at school? \_\_\_\_\_

**FAMILY LIFE**

How many people live in your house? \_\_\_\_\_ How many houses has your child lived in? \_\_\_\_\_

Has your child ever been treated by a psychiatrist, psychologist, therapist or counselor? \_\_\_\_\_ (If your child has been tested, please bring a copy to your appointment)

Has anything unusual ever happened to your child? (If so, please explain) \_\_\_\_\_

Has anyone in the extended family ever been treated by a psychiatrist, psychologist, or a doctor for nerves? \_\_\_\_\_

Name and DOB of any siblings \_\_\_\_\_

**MEDICAL HISTORY**

Who is your child's pediatrician? \_\_\_\_\_

List any medical problems: \_\_\_\_\_

List allergies: \_\_\_\_\_

List any medications the patient is currently taking: \_\_\_\_\_

What problems bring you to our office? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_