1617 Monument Avenue, Suite 202
Richmond, Virginia 23220
Phone: (804) 442-7192
www.piprva.com

Child & Adolescent Background Information

Thank you for taking the time to complete this form and bringing it with you to your initial appointment. The information you provide will enable your child's therapist to have a better understanding of your child and will help in his or her evaluation and treatment.

Today's Date: ____________________

Child's Name: ____ Age: _______
Last First Middle

Date of Birth: __________________Sex: __________________Gender: ___________________

Religion: _________________ Race/Ethnicity: ________________

Home Address: ____

School Child Attends: ___________________________________ Grade: _________________

School's Address: ____

School's Phone #: __________________________ Fax #: ______________________________

Teacher's Name and number/email:

____

Guidance Counselor's Name number/email:

____

Name of Child's Pediatrician/Family Doctor: ____

Referred by: ____ Phone: ___________________

Adults in the child's home: ☐Two biological parents ☐Shared custody ☐ Adoptive parent(s)

☐Foster parent(s) ☐Mother alone ☐Father alone ☐ Mother with partner ☐Father with partner

☐Other _________________________

Parent One Name: ____ DOB: ____________

Marital Status of Parent One: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Home Address: ____
If different from child

Home Phone: _____________________ Cell Phone: _________________________________

Email Address: ____

Employer: ____ Work Phone: _________________

What is your preferred method of contact? ____

Parent Two Name: ____ DOB: ____________

Marital Status of Parent Two: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Home Phone: _____________________ Cell Phone: _________________________________

Email Address: ____

Employer: _______________________________________ Work Phone: _________________

What is your preferred method of contact? ____

Home Address: ____
If different from child

If divorced/separated, child lives with: **Parent One**) _____% of time **Parent Two**) ______ % of time

Who has legal custody? ☐Parent One ☐Parent Two ☐Shared custody

☐Other (Foster Home, Social Services, Relative, etc.) _________________________________

Has non-custodial parent been informed of this treatment or evaluation? Yes ☐ No ☐

If shared legal custody, non-custodial parent must sign all release forms and consent to treatment forms.

REASON FOR REFERRAL: Please list your presenting concerns related to this child. If you are requesting a psychological evaluation, please let us know what questions you hope to have answered by this evaluation.

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Attempted Solutions:

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Please bring copies of your child's previous evaluations, IEPs, and most recent report cards.

List all schools previously attended and dates of attendance:

School: ________________ Location: ____________ Grade(s): ______ Dates: _______

School: ________________ Location: ____________ Grade(s): ______ Dates: _______

School: ________________ Location: ____________ Grade(s): ______ Dates: _______

Has your child ever been retained or skipped a grade? Yes ☐ No ☐

If yes, please explain.

____

Has your child ever received Special Education services or have an IEP through the school? Yes ☐ No ☐

If yes, what classification is listed on the IEP and what services are provided?

____

FAMILY MEMBERS (please include siblings, parents, grandparents, & other guardians):

Name: __________________________ Age: _______ Relationship: ____________ Occupation: ___________ Lives In ☐ Out of Home ☐ Highest Grade Completed: _______________

Name: __________________________ Age: _______ Relationship: ____________ Occupation: ___________ Lives In ☐ Out of Home ☐ Highest Grade Completed: _______________

Name: __________________________ Age: _______ Relationship: ____________ Occupation: ___________ Lives In ☐ Out of Home ☐ Highest Grade Completed: _______________

Name: __________________________ Age: _______ Relationship: ____________ Occupation: ___________ Lives In ☐ Out Home ☐ Highest Grade Completed: _______________

Name: __________________________ Age: _______ Relationship: ____________ Occupation: ___________ Lives In ☐ Out of Home ☐ Highest Grade Completed: _______________

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If any of your children were adopted, please note below.

Child's Name: ______________________________ Age at Adoption: ________________

Child's Name: ______________________________ Age at Adoption: ________________

Child's Name: ______________________________ Age at Adoption: ________________

Does your child know he or she is adopted? Yes ☐ No ☐

Do you have a current adoption social worker or involvement with an adoption agency?

If so, please list their name and contact information:

____

____

Please note if there have been previous marriages, or if there have been any deaths in the immediate family.

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Please list medical or mental health professionals currently or previously consulted:

Name: ____________________ Date: ______ Phone & Fax: ______________________

Name: ____________________ Date: ______ Phone & Fax: ______________________

Name: ____________________ Date: ______ Phone & Fax: ______________________

If you have reports, treatment summaries, or other documents from these professionals, please bring copies with you.

Please note any previous psychological evaluations of your child:

Date: _____________ Tests Given/Type of Evaluation: ___________________________

Reason for Referral: _____________________ Examiner: _________________________

Date: _____________ Tests Given/Type of Evaluation: ___________________________

Reason for Referral: _____________________ Examiner: _________________________

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Please bring copies of any previous psychological evaluations.

Please describe your child's medication history:

Medication: ____________________ Dosage: ________ Start/Stop Date: ___________________

Prescribed By: _____________________

Medication: ____________________ Dosage: ________ Start/Stop Date: ___________________

Prescribed By: _____________________

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Please list your child's greatest strengths:

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Please list the family's greatest sources of stress:

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Please tell us anything you think might be important for us to know about your child, your family, or any exceptional circumstances that might directly or indirectly affect your child:

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What do you hope to accomplish by bringing your child in for treatment and/or evaluation at this time?

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Is there anything else you would like for us to know about your child or your family?

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This form was completed by: ________________________________Date: ________________

Permission for Email and/or Text Message Communication

Email and text messaging allow Partners in Parenting therapists to exchange information efficiently for the benefit of our clients. At the same time, we must recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you give signed permission for us to send you email and/or text messages about appointments and scheduling, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging, we will continue to use U.S. Mail or telephone to communicate with you.

Parent One Name: __________________________ Parent One Signature: _____________________

☐Yes, Cell Phone ☐Yes, Email ☐ No, Decline All

Parent Two Name: _________________________ Parent Two Signature: ______________________

☐Yes, Cell Phone ☐Yes, Email ☐ No, Decline All

PERMISSION TO TREAT:

I am legally authorized as the parent/guardian of ______________________________ to enroll him/her in psychological services. I hereby authorize therapists with Partners in Parenting, PC to provide psychological treatment and/or evaluation for ______________________________.

Client/Adolescent Name: ________________________ Signature: _______________________

Minor Guardian's Parent's Name: ________________________________ DOB: ____________

Minor Guardian's Parent's Signature: ____________________________ Date: __________________

If Applicable, Guardian/Parent Two's Name: _____________________________ DOB: ____________

If Applicable, Guardian/Parent Two's Name: __________________________ Date: ___________

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Payment Policy

We are happy that you have chosen Partners in Parenting, PC (PIP). The following Payment Policy is written in order to clarify in advance our policies regarding payment for services and provide us with an opportunity to answer any questions you may have. Payment is required at the time services are rendered, unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments and outstanding account balances. Partners in Parenting (PIP) accepts cash, personal checks and credit cards. Please bring your insurance card to your first appointment. There is a $35 service charge for returned checks and no additional appointments will be scheduled until your balance is paid in full.

Your insurance policy is a contract between you and your insurance carrier. PIP is not a party to that contract. We are happy to bill participating insurance companies as a courtesy to you. Nevertheless, you are responsible for payment regardless of your insurance company's decision to deny coverage or reimburse less than the allowable charge. It is your responsibility to contact your insurance company prior to the first appointment to verify coverage.

Your insurance company contract determines the amount of your co-pay and other patient responsibilities. Co-payment/co-insurance amounts are not always clearly indicated on your insurance card. It is your responsibility to know whether or not you have a co-pay/co-insurance and to pay it at the time of service. If our staff does not "ask" you for your co-pay/co-insurance amount or if your co-pay/co-insurance is not clearly indicated on your insurance card, this is not considered a waiver of your contractual requirement with your insurance company to pay this fee nor is it to be construed as our waiver of acceptance of your co-payment at the time of service. If you are unsure, please check with your employer or call your insurance. Additionally, you are responsible for notifying your therapist of any changes in your insurance coverage.

If you do not have health care benefits or have insurance by which your PIP clinician is not an in-network provider, you are required, and you agree to pay at the time of service all charges as well as any outstanding balances and delinquent accounts.

If we have not received the payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. Questions regarding nonpayment by your insurance company should be directed to your insurance company.

You will be billed monthly for all unpaid balances deemed by PIP or your insurance company to be your responsibility. You are responsible for paying the bill in full unless special arrangements have been made in advance. Delinquent accounts may be turned over to a collection agency at which time you agree to be responsible for collection charges and all associated legal fees in addition to the amount owed.

I have read the Partners in Parenting Payment Policy, had sufficient time to be sure that I considered it carefully, asked any questions I needed to, and understand it. I understand I am

ultimately responsible for my bill even if I am using insurance or another third-party payor. I understand that PIP may refuse treatment if I do not remain current in payments for therapy services.

__________________________ __________________________ ______________

Patient or Guardian Name (print) Patient or Guardian Signature Date

__________________________ ______________

Witness Date

Credit Card Payment

It is necessary that a credit card number is kept on file with Partners in Parenting through our HIPAA-compliant and secure KASA billing program to cover any fees incurred that you are not able to cover at the time of your visit such as co-pays, items not covered by your insurance, or if you do not show for a scheduled session. This credit card will be charged at the end of each month for any outstanding bills that are not in process with the insurance company or that have exceeded the 60-day time period with the insurance company. A receipt for any transaction is available upon request.

Credit card type: ____ Number: ___________________ Exp Date: _____ CVV #: _______

Billing address (if different from bove):____

Acknowledgement

I have read the above statement, had sufficient time to be sure that I considered it carefully, asked any questions I needed to, and understand it. I understand I am ultimately responsible for my bill even if I am using insurance or another third-party payor. I authorize use of my credit card for any balances to my account with Partners in Parenting, PC such as no shows for appointments, non-payment of any session fees, or any other fees not covered by insurance if I am using insurance for my bill.

__________________________ __________________________ ______________

Patient or Guardian Name (print) Patient or Guardian Signature Date

__________________________ ______________

Witness Date

Financial Arrangements

Our fees are listed below and vary according to the type and length of service provided. PIP will file claims only with those insurance companies for which we are participants. Fees for therapy and testing not covered by insurance will need to be paid in full at the time of service. Our specialized services and evaluations will require agency or community funding. If you need a claim form to file with your insurance company, please let us know. Partners in Parenting accepts VISA, Mastercard, American Express, Discover, personal checks, and cash at the time of service.

Standard fees:

Service	Fee
Initial Clinical Appointment	$175
45 Minute Therapy Session	$125
60-70 Minute Therapy Session	$150
Family Therapy Session	$175
Psychological Testing	$150/hour
Court/Legal Testimony	$300/hour
Extended Case Management	$75/hour

Note: $75.00 will be charged for a missed 45-60 minute session and per hour for missed psychological testing sessions.