Right Track Medical Group

Child and Adolescent Patient Registration

Completed by: _____

How did you hear about us: _____

Child's Name: _____ Sex: M F Age: _____ Date of Birth: _____

Preferred name to be called: _____ Social Security Number:

_____

Ethnicity: _____ Adopted/Custody: Yes☐ No ☐ Explain: _____

Parent's or Guardian's Name: _____ Relationship to Child:

_____

Home Address: _____

Home phone: _____Work phone: _____ Cell phone: _____

Who does Child live with:

- ☐ Both Parents
- ☐ Mother
- ☐ Father
- ☐ Other: _____

Parents are:

☐ Single

☐ Married

☐ Separated

☐ Divorced

☐ Remarried

☐ Widowed

☐ Cohabitating

If divorced, what are the custody arrangements?

_____

(*Please bring copy of custody agreement for the chart)*

Please give other parent's name, address and phone number:

Name: _____

Address: _____

Cell phone: _____ Work phone: _____

Name of Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Insurance Company: _____

Phone: _____

ID# _____

Group number _____

Subscriber's Name:_____

Child's relationship to Subscriber: _____

Subscriber's Date of Birth: _____

Employer: _____

Subscriber's Address:

_____

Emergency Contact:

Name	Relationship	Phone

HOUSEHOLD MEMBERS

Name	Age	Relationship	Occupation/Grade

FAMILY MEMBERS NOT LIVING IN HOUSEHOLD (e.g., stepchildren, adult children, etc.)

Name	Age	Relationship	Occupation/Grade

AREAS OF CONCERN (check all that apply):

Personal/Social Adjustment:

- ☐ Unduly sad
- ☐ Overly anxious

problems

- ☐ Overly aggressive
- ☐ Temper Tantrums
- ☐ Withdrawn or shy
- ☐ Disturbing habits or mannerisms
- ☐ Strange or bizarre behavior
- ☐ Problems in peer relationships
- ☐ Drug or alcohol problems
- ☐ Problems with the law
- ☐ Hams self or others (suicidal or homicidal)
- ☐ Hyperactivity
- ☐ Other (Please specify):

Family Adjustment:

- ☐ Parent-child problems
- ☐ Marital conflict or co-parenting
- ☐ Sibling conflict
- ☐ Recent family changes
- ☐ Neighborhood difficulties
- ☐ Mother experiencing difficulties
- ☐ Father experiencing difficulties
- ☐ Sibling experiencing difficulties
- ☐ Drug or alcohol problems in family
- ☐ History of trauma or loss
- ☐ Domestic violence
- ☐ Abuse
- ☐ Other (please specify):

_____ _____

_____ _____

School Adjustment:

- ☐ Academic problems
- ☐ Difficulty with peers
- ☐ Difficulty with authority
- ☐ Attendance problems or reluctance to go to school
- ☐ Behavior problems
- ☐ Learning disabilities
- ☐ Attentional problems
- ☐ Other (please specify):

Physical/Developmental Factors:

- ☐ Eating
- ☐ Sleeping
- ☐ Toileting
- ☐ Grooming
- ☐ Language or speech
- ☐ Perceptual/visual functions
- ☐ Motor coordination problems
- ☐ Other, (please specify):

_____ _____

_____ _____

_____ _____

PAST PSYCHIATRIC HISTORY: CHECK THOSE THAT APPLY

Outpatient psychotherapy:	☐ Yes	☐ No	
Family therapy:	☐ Yes	☐ No	If yes, How long: _____
Individual therapy:	☐ Yes	☐ No	If yes, How long: _____
Group Therapy:	☐ Yes	☐ No	If yes, How long: _____
Inpatient (Hospital or Residential):	☐ Yes	☐ No	If yes, where and when? _____

Past suicidal ideations? ☐ Yes ☐ No Plan? ☐ yes ☐ no

Number of attempts and dates: _____

Current suicidal ideations? ☐ Yes ☐ No Plan? ☐ yes ☐ no

Most recent attempt date: _____

Method: _____

Previous diagnosis: _____

MEDICAL HISTORY:

Any significant or relevant medical problems (e.g. allergies, asthma, accidents & dates, surgery & dates, abuse & dates):

_____

_____

_____

Chronic condition or disability:

_____

Medications of any kind child is currently taking:

Medication	Dosage	Frequency	Purpose

Has child had an allergic reaction or other problems with medications? ☐ Yes ☐ No

If yes, which drugs, and briefly explain:

_____

_____

HABITS (LIST AMOUNTS AND FREQUENCY):

Alcohol or Drugs: _____

Caffeine: _____

Vitamins: _____

Herbal Supplements: _____

Exercise (amount/type/frequency): _____

Sleep: _____ Eating: _____

Other: _____

FAMILY OF ORIGIN HISTORY

Please list below family member(s) who have (or had) emotional problems, depression, anxiety, psychiatric illness, drug or alcohol abuse, attention difficulties, learning disabilities, autism, developmental delays or cognitive disabilities, abuse, neglect, suicide attempts, etc.

Family Member Relationship to Child	Problem	On-going	Resolved

DEVELOPMENTAL FACTORS

A. Prenatal History

1. Mother's health during pregnancy was: ☐ Good ☐ Fair ☐ Poor
2. Age of mother at child's birth? ☐ Under 20 ☐ 20-24 ☐ 25-29
   ☐ 30-34 ☐ 55-39 ☐ 40-44 ☐ Over 44
3. Did mother use any alcohol or substances during pregnancy? ☐ Yes ☐ No
4. Did mother smoke during pregnancy? ☐ Yes ☐ No
5. Did mother use coffee/caffeine during pregnancy? ☐ Yes ☐ No
6. Did mother have toxemia or eclampsia? ☐ Yes ☐ No
7. Was there Rh factor incompatibility? ☐ Yes ☐ No
8. Child born on schedule? ☐ Yes ☐ No

   If early, how premature _____

9. Duration of labor? _____
10. Fetal distress during labor? ☐ Yes ☐ No

11. Was delivery:

    ☐ Normal ☐ Breech ☐ Caesarian ☐ Forceps

    ☐ Suction ☐ Induced

12. Child's birth weight? _____ APAR Score (if known) _____

13. Were there complications following birth? ☐ Yes ☐ No

If yes, what were they?

_____

_____

_____

_____

_____

_____

B. Postnatal Period/ Infancy/ Toddler

1. Feeding problems: ☐ Yes ☐ No
2. Colic? ☐ Yes ☐ No
3. Sleep pattern difficulties? ☐ Yes ☐ No
4. Problems with responsiveness(alertness)? ☐ Yes ☐ No
5. Were there health or congenital problems during infancy? ☐ yes ☐ No
6. How was it to care for this child?

☐ Very easy ☐ Average ☐ Very difficult

☐ Easy ☐ Difficult

7. How did the child behave with other people?

☐ More sociable than average ☐ Average sociability

☐ More unsociable than average

8. When the child wanted something, how insistent was he/she?

☐ Very insistent ☐ Not very insistent

☐ Somewhat insistent ☐ Not at all insistent

☐ Average

9. Rate the activity level of the child:

☐ Very active ☐ Less active

☐ Active ☐ Not active

☐ Average

C. Developmental Milestones

1. Age child sat up: ☐ 3-6 months ☐ 7-12 months ☐ Over 12 months
2. Age child crawled: ☐ 6-12 months ☐ 12-18 months ☐ Over 18 months
3. Age child walked alone: ☐ Under 1 ☐ 1-2 years ☐ 2-3 years
4. Age child spoke single words other than “mama or dada”?

   ☐ 9-13 months ☐ 14-18 months ☐ 19-24 months

   ☐ 25-36 months ☐ 37-48 months
5. Age child strung two or more words together:

   ☐ 9-13 months ☐ 14-18 months ☐ 19-24 months

   ☐ 25-36 months ☐ 37-48 months
6. Age toilet trained? Bladder controlled _____ Bowel controlled

   _____
7. How long did toilet training take from onset to completion? _____ months

SCHOOL HISTORY

Current grade level: _____ Current School: _____

Has Child been held back in any grade: ☐ Yes ☐ No

Has Child failed any grade: ☐ Yes ☐ No

Has Child ever been evaluated?

School Study Team (SST)?

Individualized Educational Program (IEP)?

What was the outcome of the evaluation? Accommodations?

_____

_____

_____

_____

Learning disabilities class ☐ Dates: _____

Behavioral/emotional disorders class ☐ Dates: _____

Resource Room ☐ Dates: _____

Speech & Language therapy ☐ Dates: _____

Suspended, expelled, retained ☐ Dates: _____

Other evaluations: Psychological, Educational, Speech, Occupational Therapy:

Type of evaluation	Name and number of evaluator	Date of Exam	Outcome

_____ _____

Signature of Parent or Guardian filling forms out Date

OFFICE USE ONLY:

_____ _____

Reviewed by Signature Date

By electronically signing this form you agree your electronic signature is the equivalent of your manual/handwritten signature on this form/agreement. You also agree that the electronic signatures appearing on this form/agreement are the same as handwritten signatures for the purposes of validity.

RightTrack MEDICAL GROUP

Right Track Medical Group

Consent and Acknowledgment Form

Welcome to Right Track Medical Group. This document contains important information about our services and business policies. We can discuss any questions you have when you sign them or at any time in the future.

Patient Name_____ DOB_____

Consent for Mental Health Services. I voluntarily consent for care encompassing diagnostic procedures and treatment by my physician/nurse practitioner, therapist, his/her assistant, designees or consultants, as may be necessary in the judgement of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of treatments or examinations in this clinic. I understand that my medical record may be maintained on a computer-based system and is available to persons involved in my care.

Patient or Responsible Party Initials_____

Authorization to Release. I hereby authorize Right Track Medical Group and any provider caring for me to release or disclose to insurance companies and / or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Patient or Responsible Party Initials_____

Communication: I hereby authorize Right Track Medical Group to communicate with me via voice mail in the event I cannot be reached directly. The phone number on which a voice mail may be left is

_____.

Patient or Responsible Party Initials_____

Release from Responsibility. If I should leave the clinic against medical advice or prior to treatment being completed, I hereby relieve said physicians/ nurse practitioner, therapists and the clinic of all liability for my action.

Patient or Responsible Party Initials_____

Guarantee. Right Track Medical Group is a fee-for-service mental health practice that strives to provide immediate care for patients needing its' services. I understand that I must pay for these services on the date care is rendered. I understand that Right Track Medical Group will file my insurance under out-of-network coverage benefits I may have.

Fee Schedule:

Initial Assessment (1st Appointment) $150
Initial Appointment with Psychiatrist / Nurse Practitioner $350
Follow-up Medication Management $175
Individual Therapy Session $150
Family Therapy Session $250
Group Therapy Session $75

Patient or Responsible Party Initials_____

Assignment of Benefits. I request that any payment of authorized benefits for which I am entitled and which are otherwise payable to me and related to this claim be made on my behalf directly to Right Track Medical Group.

Patient or Responsible Party Initials_____

Cancellation / No Show Policy: If you will arrive 15 minutes past your scheduled time, please call. It may be possible to work you in when an opening arises, accommodate you at the end of the day, or reschedule your appointment. I also understand that if I cancel a scheduled appointment less than 24 hours prior, or if I fail to show for a scheduled appointment, I will be responsible for payment equal to the normal fee for the scheduled service. Patients who no-show or cancel two (2) or more times without 24-hour notice may be required to secure next appointment with credit/debit card or may be dismissed from the practice and thus they will be denied any future appointment(s). Our fee to be charged to you for cancellation/No show is $125.00 and you will be responsible for paying this fee before another appointment will be made.

Patient or Responsible Party Initials _____

Payment Terms. I understand that payment in full is due on the date of treatment for all services provided, and I agree to pay all charges for the patient named below. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance

Patient or Responsible Party Initials_____

Acknowledgment of Receipt of Notice of Privacy Practices. I hereby acknowledge that I have received, read and had an opportunity to ask questions concerning Right Track Medical Group's Notice of Privacy Practices

Patient or Responsible Party Initials_____

I have read and initialed all of the above and I certify that I understand and agree to its content.

_____	_____
Date	Patient or Responsible Party Signature
_____	_____
Date	Staff Witness Signature

RightTrack MEDICAL GROUP

CONSENT TO TREAT MINOR

We require the consent of a parent or legal guardian to provide care for patients under the age of 18. ***PLEASE NOTE we do not see patients under the age of 18 years old for appointments without an adult accompanying them and strongly encourage a parent or legal guardian to attend all appointments.*** *Please sign the first authorization below to allow us to care for your child. If you would like us to care for your child, if the child comes in alone or brought in by another person, please sign the second authorization below as well.*

Patient's Name:_____

Date of Birth:_____

1. **Authorization to treat a minor patient when accompanied by a parent or legal guardian.**

   As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed by Right Track Medical Group.

   Printed Name of parent/guardian: _____

   Signature of parent/guardian: _____

   Date: _____

2. **Advance authorization to treat a minor patient when not accompanied by a parent or legal guardian.**

   I am the parent or legal guardian of the patient named above. If the patient comes into the clinic alone or is brought in by any other person/persons listed below, I give advance authorization and consent for the minor to seek counseling, psychotherapy, psychological assessment and/or psychiatric care from the professional staff associated with or employed with Right Track Medical Group.

Approve to bring child to appointments	Relationship to child

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

_____ _____

(Parent/Legal Guardian, Print) (Parent/Legal Guardian, Signature)

_____

(Date)

1203 Medical Park Drive Oxford, MS 38655 p: 662.234.7601 f: 662.234.8531

Consent to Discuss Treatment

Patient Name: Date of Birth:

_____ _____

First MI Last

Check one:

☐ **I authorize Right Track Medical Group to discuss my child's treatment with the following individuals I have listed below:** [Please Print]

_____ _____

Name Relationship

_____ _____

Name Relationship

☐ **I do not authorize discussion of my child's treatment with any other individuals.**

_____ _____

Parent/Guardian Signature Date