Center for Child and Family Therapy

Intake Form

Client Name: _____ DOB: _____ TODAY'S DATE: _____

SSN of Guarantor: _____ Age: _____ Gender: _____ Marital Status:_____

Address: _____ City: _____ State: _____ Zip code: _____

Employer/school: _____ Phone: _____

Person filling out form: _____ Relationship to client: _____

Emergency contact: _____ Phone:_____

Preferred method for appointment reminders: ❑ **Home phone** ❑ **Cell Phone** ❑ **Email**

Home phone: _____ Can a message be left? ❑ Yes ❑ No

Cell phone: _____ Can a message be left? ❑ Yes ❑ No

Email: _____ Can a message be left? ❑ Yes ❑ No

FAMILY INFORMATION (Others in household)	**DOB**	**Relationship to client**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION

Primary insurance name: _____ Employer: _____

Subscriber Name: _____ Subscriber SSN:_____

Date of Birth: _____ Relationship: _____

Policy number: _____ Group number: _____

Secondary insurance name: _____ Employer: _____

Subscriber Name: _____ Subscriber SSN:_____

Date of Birth: _____ Relationship: _____

Policy number: _____ Group number: _____

Primary Care Physician: _____ Phone: _____

Referred by: _____

Please describe the main problems that led you to therapy: _____

_____

_____

_____

Child Psychiatry Office Policies and Procedures **Melanie Brace, MD**

I am a board certified Child and Adolescent Psychiatrist with over 25 years of clinical experience. Please feel free to obtain more information about my credentials on our website at ccftherapy.com

The following policies are outlined to help insure the best clinical care of you/your child.

Consent: You will be asked to sign consent for treatment, insurance billing and release of information as appropriate. Please keep in mind that youth 13 and older must also sign any consents for their care or release of information.

Appointments: Intake sessions are conducted over two sessions lasting 50 minutes each. Occasionally additional sessions are needed for more complicated care or situations. Parents will attend without the child at the first session then together with the child at the second visit unless the child is 13 or older in which case both parent and patient attend both intake visits. You may be asked to obtain information from teachers or your child's school and will be asked to complete symptom questionnaires to aide assessment of your child. Follow up visits are usually 30 or 40 minutes for medication management/assessment or 50 minutes if additional therapy is needed. Please try to be on time for sessions as your session may not be able to be extended. You will be charged a fee for missed appointments or if you fail to cancel/reschedule a visit within 48 hours of the appointment. Fees and policies around payment are included in a separate form. New patients are screened prior to the first visit to insure that the assessment will meet their needs. The first two appointments should be scheduled within one or two weeks of each other for continuity of care. Please try to avoid rescheduling intake sessions if at all possible.

Release of Information: You/your child may request that I communicate with a therapist or school personnel. Children 13 and older as well as parent/guardian will need to provide written consent for this exchange of information. As a rule I do not send my records to the school. You can request a copy of records and will be asked to review them carefully prior to sharing them with the school as there may be confidential information that either you or your child would not wish to share. I may request a visit with you/your child to review the contents of the record before sharing it with anyone to insure confidentiality.

I can provide a letter for the school with brief information to help support a 504 or IEP referral. Letters are provided at no cost to you if requested during a patient session. Please see the Fee form for additional charges for copying records or for letters.

Custody/Parental Involvement: The parent requesting the evaluation and attending sessions will be considered the guarantor and asked to sign the guarantee of payment. If parents are divorced or unmarried and there is joint medical authority, ideally, both parents are involved in the evaluation and treatment. Nevertheless, your child's care will be provided in consultation with the parent presenting with concerns so long as they have medical decision making authority. If a parent disagrees with the treatment plan they are strongly encouraged to make an appointment to share concerns, history and participate in the care of their child. I will not be able to communicate with parents by phone about their child's condition if they have not participated in office appointments. Phone appointments can be made but need to be paid in advance by check.

Parents sometimes go to court to assert treatment needs. I can provide a letter or records regarding treatment if needed but cannot provide any input about custody itself. Parents are encouraged to communicate openly with each other unless the teen wishes to keep their health concerns confidential. Records may be released to a parent with joint medical decision making authority for younger children but teens will need to sign release. Please see Fee sheet for fees that apply.

Communication: I am in the office one or more days of the week but check my voicemail every day of the week including weekends and holidays. I will return urgent calls within one business day and other calls within a week. I will check email Mon- Friday. Please do not communicate by email about any health or medical concern or crisis as I cannot fully guarantee the confidentiality of email and will not check it as frequently as my voice mail.

I hereby consent to evaluation and treatment of myself/my child for mental and behavioral health concerns. I acknowledge that I have read the policies above and agree to communicate with Dr. Brace regarding any questions or concerns that arise in the course of treatment.

Patient_____

Parent/guardian _____ Date _____

I, _____ have reviewed the fee information provided by Dr. Brace and agree to pay for any and all services provided by Dr. Brace for the care of my child named below including those not covered by my health care insurance.

I understand that my child's/my health information is strictly protected. I have received information outlining how information is protected and agree to have CCFT or Dr. Brace release information to my insurance for the purpose of billing and claims processing.

Parent/Guarantor _____

Patient if older than 13_____ Date _____

Patient Name _____DOB_____

Fee Sheet: Melanie Brace MD

Intake sessions

Intake involves two separate 50 minute sessions to insure confidential time for child and parent to relay history and to allow time for review of questionnaires or discussion with therapist for diagnosis and treatment planning. Children under the age of thirteen do not attend the first session. Adolescents thirteen and older attend both sessions. Parents are expected to attend all sessions except f/u for teens 16 and older.

- **1st Session 90792** **$250**
- **2nd Session 99215 and 90833** **$200-$300**

Note: These are **Maximum** charges and actual charges will likely be lower based on your insurance contract rate or if there is an adjustment for out of network insurances.

Follow up session

Follow up sessions may be 30 or 50 minutes depending on patient need. When medications are prescribed patients may need to be seen monthly, every other month or every three months. If the patient is stable, then referral back to the primary care provider is an option for ongoing management of medications if the PCP is willing to resume care.

- **30 Minutes: 99213/99214 (plus 90833)** **$150 - 200**
- **60 Minutes: 99215 (plus 90833/36)** **$200 - 335**

Codes vary depending on complexity of care and type of need during the session so charges will vary. Above is **Maximum** cost for session. Please make payments to Melanie Brace MD, the name on your billing statement and insurance statement.

Missed appointments

Follow through with care is very important for mental health recovery and symptom management. Occasionally there are unexpected or sudden problems that prevent coming to a session. Sessions may be able to be converted to a Telepsych visit in some instances. Since your appointment is reserved for you and usually cannot be rescheduled at the last minute you will be charged a fee for any no shows or late cancellations. The fees are meant to cover expenses for the practice and are not punitive, however, if multiple sessions are missed you may be referred to a new provider. Visits need to be cancelled 48 hours in advance of your appointment to avoid a fee.

First missed visit or unavoidable reason for missing visit: **$25 for half hour, $50 for hour**

Subsequent missed/late cancelled visits: **$100 for half hour, $200 for hour**

Telephone consult

Families may be charged for telephone calls (separate from Telepsych visit) if there is a request to change the clinical plan between sessions, the call is lengthy, the call is a crisis, or the call is in lieu of a cancelled appointment. Routine/straightforward calls that are brief will not be billed.

- **11 – 20 minutes** **99442** **$75**
- **21 – 30 minutes** **99443** **$100**

Payment

Dr. Brace is contracted with **Regence Blue Shield, Premera Blue Cross and Aetna** through her practice at CCFT. You will be asked to pay at time of service any deductible or copay due. Please be aware that your insurance may not cover the visit if you are out of network. We will, however, bill your insurance as a courtesy to you but expect payment in full at each visit if you are out of network. We request that you make payment by check or cash at the time of service. Otherwise you can call the office ahead of time to make a payment by credit card.

Miscellaneous Fees

- **School visit** or other collaborative care meeting**: $250/hour**
  This is not a covered service so will be billed directly to family and includes travel time if lengthy.
- **Release of Records**: After appropriate consents are signed a **$30 fee** will be assessed for release of records with $1 per each page over 10 pages.
- There is a **$35** fee for **insufficient funds/returned checks** in addition to outstanding charges.
- **Court consultation** by phone or appearance in person**: $350/hour** including travel time.
- **Balances for service need to be paid within 30 days of billing unless otherwise arranged with Dr. Brace.**

Child / Adolescent Psychiatry Intake Form

Patient Name: _____ DOB:_____

Parent/Legal Guardian/s:

_____

School:

_____Grade:_____

Members of household: Names, Ages, relationship to patient:

_____
_____
_____
_____

_____

Reason for Referral:

_____
_____
_____
_____
_____

Prior/ current mental health evaluations and treatments:

_____
_____
_____
_____
_____

Family history of mental/physical health problems (depression, anxiety, ADHD, learning disorders, Autism, substance or alcohol abuse, heart disease, diabetes, etc.:

- **Birth mother: _____**
- **Birth father: _____**
- **Siblings: _____**
- **Maternal relatives:**

  _____
  _____
- **Paternal relatives:**

  _____
  _____

Social history:

(Please Describe)

- **Friendship/peer relations:**
  _____
  _____
  _____
- **Extra-curricular activities:**_____
  _____
  _____
- **School academic and social ability:**
  _____
  _____
  _____

Health History:

- **Pregnancy and Childbirth// Please list any areas of concern:**
  _____
  _____
  _____

- **Milestones of Development / Please list any areas of concern or delays:**
  - **Motor skills:** _____
  - **Language skills:**_____
  - **Interactions with others**_____
  - **Toilet training/hygiene:** _____
  - **Cognition/learning:**_____

- **Medical History:**
  - **Surgeries:** _____
  - **Illnesses:**
    _____
    _____
    _____
  - **Allergies:** _____
  - **Therapies/OT/PT/Speech:** _____

- **Current medications, vitamins, supplements:**_____
  _____
  _____
  _____
  _____