WELCOME!

This is to confirm ________________________________'s appointment with
Patient's Name

____
Provider Name

at our MK Plus office on ____________________, ____________________ at
Day Date

________________.
Time

Our office is located at:

31 Cambridge Lane Suite A
Newtown, PA 18940

Please do not hesitate to call us at **215-968-5151** should you require directions to our office. If you prefer, you can print directions from our website www.mkplusnewtown.com

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office 215-968-5151 should you have any questions prior to your visit.

If for any reason you need to cancel or reschedule your intake appointment, we ask that you provide our staff with as much notice as possible. **Please call our office 2159685151** and leave a message in our general mailbox and we will take care of notifying the provider.

We look forward to meeting you!

BACKGROUND INFORMATION

Name: ___________________________________ Date of Birth: _______________________

Address: ____

Phone #: Home__________________ Mom Cell _____________ Mom Work ______________

Phone # Dad Work: ___________________________ Dad Cell: _____________________

Child Cell (if applicable) ____________________

School: ________________________________ Grade __ Date form completed: ___________

PRESENTING CONCERN:

Please describe the main difficulty that has brought your child to see me:

____

____

REFERRAL SOURCE:

Who referred you to our office? ____________________________________

Can we have your permission to thank them for the referral? ______________________________

FAMILY HISTORY

Your child lives in the home of: (__) Biological parent(s) (__) Adoptive parent(s) (__) Foster parent(s) (__) Other

Since birth, how many homes has your child lived in? ______

Reasons for moving? ____

Mother's Name: ____
Date of birth: ___________________________
Highest level of Education: ___________________________________
Occupation: ____
Place of Employment: ____________________________________
Is mother living in the home? ____________
Amount and type of contact with child: _________________________

Father's Name: ____
Date of birth: ____________________________
Highest level of Education: ____________________________________
Occupation: ____
Place of Employment: ____
Is father living in the home? ____________
Amount and type of contact with child: __________________________

Child's brothers and sisters (Please list beginning with the oldest)

Name	Age	Living at home?	School or Occupation

List other relatives living in the home:

____

Are there any activities that your family does together?

____

What is the primary language spoken in the home?

____

<u>DEVELOPMENTAL HISTORY</u>

PREGNANCY

Mother's health during the pregnancy: (__) Good (__) Fair

Any illnesses or complications during the pregnancy? (Explain)

____

____

List any medications taken during pregnancy:____

Drug use? (__) Mother (__) Father ***Alcohol Use?*** (__) Mother (__) Father ***Smoking?*** (__) Mother (__) Father

Length of Pregnancy: _______ weeks Labor: ______ hours

Type of Delivery: (__) Natural (__) Cesarean (__) Breech

What drugs were used during labor and delivery?_____________________________________

Birthweight: _____ pounds _____ ounces

Complications (if any):

Condition at birth: ____________________________________ APGAR score (if known): ___

Jaundiced? _________________ Oxygen needed? _____________Incubator? __________

Transfusion needed? ______________Length of hospital stay: Infant _______ Mother _____

EARLY DEVELOPMENT

Who was the primary caretaker when your child was an infant?

____

Any long separations from the mother? (Explain)

____

____

Were there any feeding problems? (Allergies to milk/formula- Please explain)

____

____

At what age did your child:

Sit without support? _________________
Crawl? _________________
Stand? _________________
Walk? _________________
Speak first word? _______________
Speak in phrases? _________________
Dress/undress self? _________________

Describe any problems with speech/language:
____

At what age was toilet training initiated? ______________________Completed? ___________ Any accidents after that? ____

Is your child left or right handed? ______________________________________

Does your child sleep alone in his/her own bed? _________________________

MEDICAL HISTORY

Name of Physician: _______________________________________ Telephone: ___________

Please check all the illnesses/conditions that your child has had. All checked boxes must include an approximate date in the space provided below:

(__) Measles (__) German Measles (__) Chicken Pox
(__) Mumps (__) Whooping Cough (__) Scarlet Fever
(__) Rheumatic Fever (__) Tonsillitis (__) Pneumonia
(__) Asthma (__) Epilepsy (__) Croup
(__) Ear Infection (__) Wax Build-up (__) Fever of >/= 102 degrees
(__) Lead Poisoning (__) Loss of Consciousness (__) Convulsions/Seizures
(__) Allergies (Specify): ____

Please include date(s) for any illnesses checked above:
____

____

Tubes in ears? (__) Which Ear(s)? (__) Left (__) Right (__) Both

When? ____

Other serious illness or injury? (Describe):
____

____

Hospitalizations? (__) Yes When? __________ What for? __________________
(__) No

List any medications currently taking:____

FOR YOUNG WOMEN ONLY

At what age did your daughter start to menstruate (get her period):
____

Menstrual period experiences:

-How regular are they? ____

-How long do they last? ____

-Any Pain? ____

-How heavy are her periods? ____

-Other experiences during periods? ____

HEALTH HABITS

What kinds of physical exercise does your child get? ______________________________________

____

How much coffee, cola, tea or other sources of caffeine does your child consume each day? __________

____

Do you try to restrict your child's eating in any way? How? Why? _____________________________

____

Do you have any problems with your child getting enough sleep? ______________________________

____

SOCIAL RELATIONSHIPS

Does your child make friends easily?
____

Does your child have many friends?
____

In the neighborhood? ________ In school? ________________
Does your child participate in organized activities? If yes, which ones?____________________

Does your child prefer to associate with older people, younger people, or those the same age?

Does your child have difficulty keeping friends?

How does your child get along with others in your family?

Parents? ______________________________

Siblings? ______________________________

How is your child disciplined? ______________________________

ACADEMIC HISTORY

Describe your child's attitude, motivation and grades in school:

Explain any current school problem(s) and any previous difficulties:

Does your child currently have an IEP, a 504 or any other type of academic support?

Has your child received any previous educational or neuropsychological testing? (Describe)

List other family members who have had difficulties with school (Explain):

Areas of concern (Check all that apply):

(__) Aggressive Behavior
(__) Daydreaming
(__) Temper tantrums
(__) Getting along with sibling
(__) Getting along with others
(__) Depression

(__) Low self esteem
(__) Comprehending things said to child
(__) Failing grades/poor academic performance
(__) Fears (Explain fully):____

(__) Anxiety
(__) Completion of school work
(__) Saying what they want to say

____
(__) Other (Explain fully):____
(__) Attention difficulties (Explain fully):____
____
(__) Significant change in behavior (Explain fully):__________________________________

Have there been upsetting events and/or significant losses in the life of your child or your family? (Explain):
____

____

To your knowledge, has your child ever been abused in any way (physically, verbally or sexually)? ( ) Yes
( ) Not to my knowledge If yes, please explain____________________

____

Describe your child's morning routine:
____

____

Describe your child's evening routine:
____

____

What are your child's strengths?
____

____

What do you see as his/her areas of need?
____

____

Has your child received any previous educational or psychological testing, therapy or remediation? (Describe)
____

____

Has your family or any family member had previous contact with a mental health agency, psychiatrist, or psychologist? (Describe)

____

____

What other additional information would you like to include that may assist us with this evaluation?

____

____

____

____

____

____

____.

PAYMENT POLICY

Two copies of this policy are being provided to you. Please review it carefully and sign one copy where indicated. Return the signed copy to our office at the time of your next appointment. The second copy is for you to retain for your reference.

Thank you for your cooperation.

MK Plus Behavioral Health Providers **<u>do not</u>** currently participate with any insurance plans.

MK Plus Behavioral Health services are provided on a payment-for-service basis.

All fees will be discussed and agreed to by you prior to the initiation of treatment.

Full payment is due at each visit and will be collected upon check-in for the appointment. Our office does not *bill* for any services rendered. The fee for these sessions with ____are ____________________.

For the convenience of our clients, our office accepts the following credit cards: Master Card, Visa, American Express and Discover.

For your convenience, our office <u>will</u> retain your credit card information in a locked and secure file for the duration of the treatment and charge for visits as they occur.

Upon payment, each client will be provided with a receipt. This receipt will be appropriate for submission to your insurance company should you be entitled to any reimbursement for services provided.

Our office requires <u>24 hours advance notification</u> of any appointment that you wish to cancel and/or reschedule. If for any reason you need to cancel, please call our office at 215-968-5151 and leave us a message in our general mailbox. We will take care of notifying the provider. Out of courtesy to other clients waiting for appointments, please note that you will be charged for any appointment where you do not show up or you cancel the appointment less than 24 hours in advance.

Your signature below acknowledges receipt and understanding of the above payment policies.

_____________________________________ ____

Client Name (Please Print) Client Signature

____

Date

(OFFICE COPY)

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Upon payment, each client will be provided with a receipt. This receipt will be appropriate for submission to your insurance company should you be entitled to any reimbursement for services provided.

Our office requires 24 hours advance notification of any appointment that you wish to cancel and/or reschedule. If for any reason you need to cancel, please call our office at 215-968-5151 and leave us a message in our general mailbox. We will take care of notifying the provider. Out of courtesy to other clients waiting for appointments, please note that you will be charged for any appointment where you do not show up or you cancel the appointment less than 24 hours in advance.

Your signature below acknowledges receipt and understanding of the above payment policies.

_______________________________________ _______________________________________

Client Name (Please Print) Client Signature

____

Date

(CLIENT COPY)

CREDIT CARD AUTHORIZATION

MKPlus requires that you provide your credit card to be retained on file in our secure electronic medical system. Please complete the information below and bring it with you to the next session. ***NOTE: No charges will be made to the credit card unless you request to use this card for payment of services, or in the event of the non-payment of services, missed session, or cancellations within 24 hours.***

This authorization will be good for a period of twelve (12) months. -You authorize these charges to your credit card and understand that you will be provided a receipt for anything charged to your card. A receipt for each payment will be mailed to you and the charge will appear on your statement as "MKPlus." MKPlus accepts Visa, MasterCard, American Express, and Discover cards for payment of fees.

PATIENT'S INFORMATION			
Patient's Last Name:	First Name:	Middle:	OP ID:

PAYMENT METHOD INFORMATON		
Name as it appears on the card:		
Street Address:		
City:	State:	ZIP:
Maximum Charge Amount: (Charges up to the Patient's individual annual deductible will be charged unless other amount is listed.)		
Please charge to the following:	**Credit card:** ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover	**Other:** ☐ Health Savings Account ☐ Flexible Spending Account
Expiration Date: ________ / ________	Last 4 Digits of Card Number: (Must have card on hand in office to store securely) X X X X - X X X X - X X X X - _ _ _ _	
Card holder's signature:		
Date:	Phone number:	

HIPAA Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices for MK Plus and I have been provided an opportunity to review it.

Patient name: _____________________________________

Name of person reviewing the information (if someone other than patient)

_________________________________ Relationship to patient: ____________

Patient Date of Birth: _______________

Signature: ____ ______________ *Patient or Patient Representative* *Date*

Disclosure of My Personal Health Information

I request the following allowance for the disclosure of my health information:

(In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information)

Name of Individual	Relationship to Patient (parent, sibling, relative, friend etc)

Messages on Answering Machine/Cell Phone

Can we leave detailed messages on answering machine? ( ) Yes phone number ( ) ( ) No	On your cell phone? ( ) Yes phone number ( ) ( ) No

Authorization for Consent to Treat a Minor

I, ____, hereby authorize

Name of parent or legal guardian

________________________________ to bring my child ______________________

Name of person authorized to bring child to appointment *Name of Child*

to his/her appointments at MK Plus. The authorization shall be limited to the following time period: ____. If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization. Signature _____________________________ Date ______________________