

3. Has your child previously had any treatment for mental health symptoms?		
4. Has your child ever been given a mental health diagnosis (i.e. ADHD, Depression, Autism)? If yes, what diagnoses? If no, what diagnosis do you suspect?		
5. List all <u>outpatient</u> clinics or mental health centers that your child has visited for the treatment of mental health symptoms within the past <u>two</u> years:		
Clinic or Center	Reason for Visits	Estimated # of Visits
6. Has your child ever had <u>inpatient</u> or <u>residential</u> treatment for mental health symptoms? If yes, list below:		
Facility	Reason for Hospitalization	Dates of Stay

Allergies, Medications, and Medical Concerns

7. Does your child have any known medication allergies? If yes, list:				
8. Does your child have any other known allergies? If yes, list:				
9. Has your child ever taken vitamins, nutritional supplements or other non-prescription medications to treat mental health concerns (i.e. autism, ADHD)? If yes, list any treatments ever taken below:				
Treatment Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped

--	--	--	--	--

10. List all current medications and doses below:

Medication	Dose (how much & how often)

11. List all past medications used for emotional or behavioral problems below:

Medication Name	Dose (how much & how often)	Date Started	Date Stopped	Why Stopped

12. Is your child currently being treated for any medical illnesses?

If yes, please list:

--

13. Has your child ever had surgery or been hospitalized for medical reasons?

Facility	Reason for Surgery or Hospitalization	Dates

Child's Personal and Education/School History

14. Please write the age at which your child was able to do the follow things. It is okay if your child is not able to do some of these yet.

--

First Walked?	Was toilet trained?
Said first words?	Used 2-3 word phrases with meaning?
15. Has your child had any loss of skills for the milestones listed above?	
If yes, what skills were lost and at what age? Please list below:	
Skill	Age of child when skill lost
16. Had legal problems (i.e. court appearance, probation)?	
17. Received any of the following services below:	
Physical Therapy yes or no	Speech Therapy yes or no Occupational Therapy yes or no
18. Has your child ever received any special education services at school?	
19. Does your child have an IEP (Individualized Education Plan)?	
20. Has your child had significant disciplinary actions (i.e. suspensions, expulsions) at school?	
21. Has your child had social problems (i.e. isolated or difficulty getting along with peers)?	
22. Have teachers voiced concerns about your child's success at school?	
If yes, please list teacher concerns about your child's success at school:	

Demographic and Birth Information

23. Race (circle all that apply)	Caucasian	African-American	Hispanic	Asian
Native Hawaiian or Pacific Islander	Native American	Other (specify):		
24. Age of biological mother at child's birth:	25. Number of previous pregnancies:			
26. Was biological mother exposed to toxins in pregnancy (i.e. medications, tobacco, street drugs, alcohol)?				
If yes, list toxins:				
27. Any complications during this pregnancy?				
If yes, circle all that apply: Bleeding Bed rest required Others, please list below:				

28. Full-term: or no	yes	29. Child's birth weight:
30. Child home within 3 days after birth: or no	yes	If not, please list cause below:

Family/Home Information

31. Potential stress history for child (circle all that apply)		Arrest/convictions of family members		
Parental Divorce	Parent separation or marital problems	Exposure to firearms in home		
Domestic Violence	Serious Illness in family	Death in family		
Others, please list:				
32. List all immediate (biological) family members. Also list other living in the home.				
Relation	Name	Age	Living in Home?	Children: current grade in school Adults: highest level of education
Bio Father				
Bio Mother				
33. Are there any <u>biological</u> family members of the child who have had <u>any</u> of the following?				
<ol style="list-style-type: none"> 1. Significant medical conditions (i.e. seizures, sudden death) 2. Autoimmune disorders (i.e. lupus, multiple sclerosis) 3. Psychiatric conditions (i.e. anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD) 4. Neurological conditions (i.e. mental retardation, learning problems, language delay, tics) 5. Drug/alcohol problems 				

Relationship to Child (father, mother, brother, sister, grandmother, cousin, uncle, etc.)	Name or Description of Conditions (Please include all categories listed above)

Satyen P. Madkaiker, M.D. & Associates	Consent for Psychiatric Evaluation and/or Treatment	Name: Date of Birth:
----------------------------------------------	----------------------------------------------------------------	-------------------------------------------

-
1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Priset, P.A.. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
 - a. The benefits of the proposed treatment
 - b. Alternative treatment modes and services
 - c. The manner in which treatment will be administered
 - d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
 - e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychiatrist. Treatment will be conducted within the boundaries of Florida Law for Psychiatric and Professional Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Priset, P.A., and I consent to disclosure for use by Priset, P.A. staff for the purpose of continuity of my child's care. Per Florida mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Signature of legal guardian for minor under age 18 Date

Signature of witness Date

AUTHORIZATIONS / AGREEMENTS

Please read the following and sign below:

- I understand that for all medication refills, I am expected to make an appointment to be seen by my provider. I understand that medications will not be called in to a pharmacy or approved by fax without being seen.
- I understand that for certain medications, I have the choice of being discharged from the care of PRISAT, PA into the care of my PCP ("Primary Care Physician").
- I understand that payment in full is due at time of service for all copays / coinsurance / deductibles that are my responsibility and that if I arrive without full payment, I will not be seen and my appointment will be rescheduled.
- I understand that if my insurance company fails to pay my balance in full, or there is no payment within 90 days, it is my responsibility to pay the bill directly to PRISAT, PA.
- I authorize PRISAT, PA to bill my insurance company(ies) directly for services provided.
- I authorize payment of any insurance benefits payable to me to be paid directly to PRISAT, PA. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to PRISAT, PA.

- I authorize PRISAT, PA to release or receive any information necessary to expedite insurance claims.
- I understand that I am directly and fully financially responsible to PRISAT, PA for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover THR fee.
- I understand that a consultant report may be forwarded to my PCP (“Primary Care Physician”) and/or my referral source for my medical record. If I have been referred by an EAP (“Employee Assistance Program”), communication may be given to my EAP, if requested by them.
- I understand that if I fail to keep my appointment, or do not cancel 24 hours prior to my appointment, I shall be charged a \$25 no show/late cancellation fee.
- I understand that there will be a \$35 charge on all returned checks and that if a check is returned, I will lose check writing privileges at PRISAT, PA.
- I understand that if I am on the Suboxone (Buprenorphine) Treatment Program, that NO CHECKS will be accepted. (Forms of payment accepted will be: cash, credit, or money order).
- I understand that I will be charged for non-emergency calls answered by the answering service. The charge is \$5.00 per call for calls received Monday through Friday and the charge is \$15.00 per call for calls received on Saturday, Sundays, and holidays.
- I understand that the charge for having paperwork completed is \$20.00 for the first page and \$15.00 for each page thereafter.
- I have received a copy of the “Notice of Privacy Practices” and I have been provided an opportunity to review it.
- I understand that a photocopy of these authorizations / agreements shall be as valid as the original.

Patient Signature _____

Date _____

Parent / Guardian Signature _____

Witness Signature _____

NOTICE OF PRIVACY PRACTICES

PATIENTS - PLEASE RETAIN THESE TWO PAGES FOR YOUR RECORDS.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical

information about you. We also describe your rights and certain duties we have regarding the disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is not in effect.

We Have the Right To:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information

previously created or received before the changes.

Notice of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting accreditation, certificates, licenses, and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposed in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, or Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations of proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the changes and to include the changed in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at this office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or think that we may have violated your privacy rights, please contact us at: Privacy Office; PRISAT, PA; PO Box 24330; Jacksonville, FL 32241-4330. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

4. YOUR INDIVIDUAL RIGHTS

You have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the forms you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$1.00 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations, and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by

