PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC
9601 BAPTIST HEALTH DRIVE, SUITE 1050
LITTLE ROCK, AR 72205

CONSENT FOR EVALUATION, PSYCHOTHERAPY, PSYCHOPHARMACOLOGY AND/OR TREATMENT OF A CHILD

A child aged 17 years and under must have the consent of his/her (custodial) parent or guardian to receive psychiatric services including psychotherapy, evaluation, or other treatment. *In cases of divorce, only the custodial parent can give consent.*

So that we can comply with the law, please complete the following:

Check and initial one:

_____ I am the parent of the below named minor child. There have been no divorce or legal separation proceedings between the child's other parent and myself.

_____ I am the custodial parent of the below named minor child as designated in divorce proceedings. I understand that I must furnish a notarized copy of the divorce decree section stating that. I agree to provide this office with a notarized copy of any changes in custodial status of the child.

_____ I am the (custodial) parent of the below named minor child. My spouse and I have a legal separation.

_____ I have joint custody with my ex-spouse of my child.

_____ I am the below named child's legal guardian. I understand that I must furnish a notarized copy of the guardianship papers.

_____ I am the sole legal parent of the below named minor child.

I agree to inform the office if there are any changes in my child's custodial status for any reason. I hereby give my permission for Psychiatric Associates of Arkansas, PLLC, (to include Duong Nguyen, M.D.; Richard Owings, M.D., Ph.D.; Philip Mizell, M.D.; Marcela Johnston, Ph.D.; Nancy (Beach) Golden, LPEI; Garry Teeter, LPC; Nancy Kozlowski, LPC; Lindsay (Crane) Oliver, LPC; Ally Orsi, LCSW) to provide psychiatric services for:

_____ DOB: _____
(Name of Minor Child)

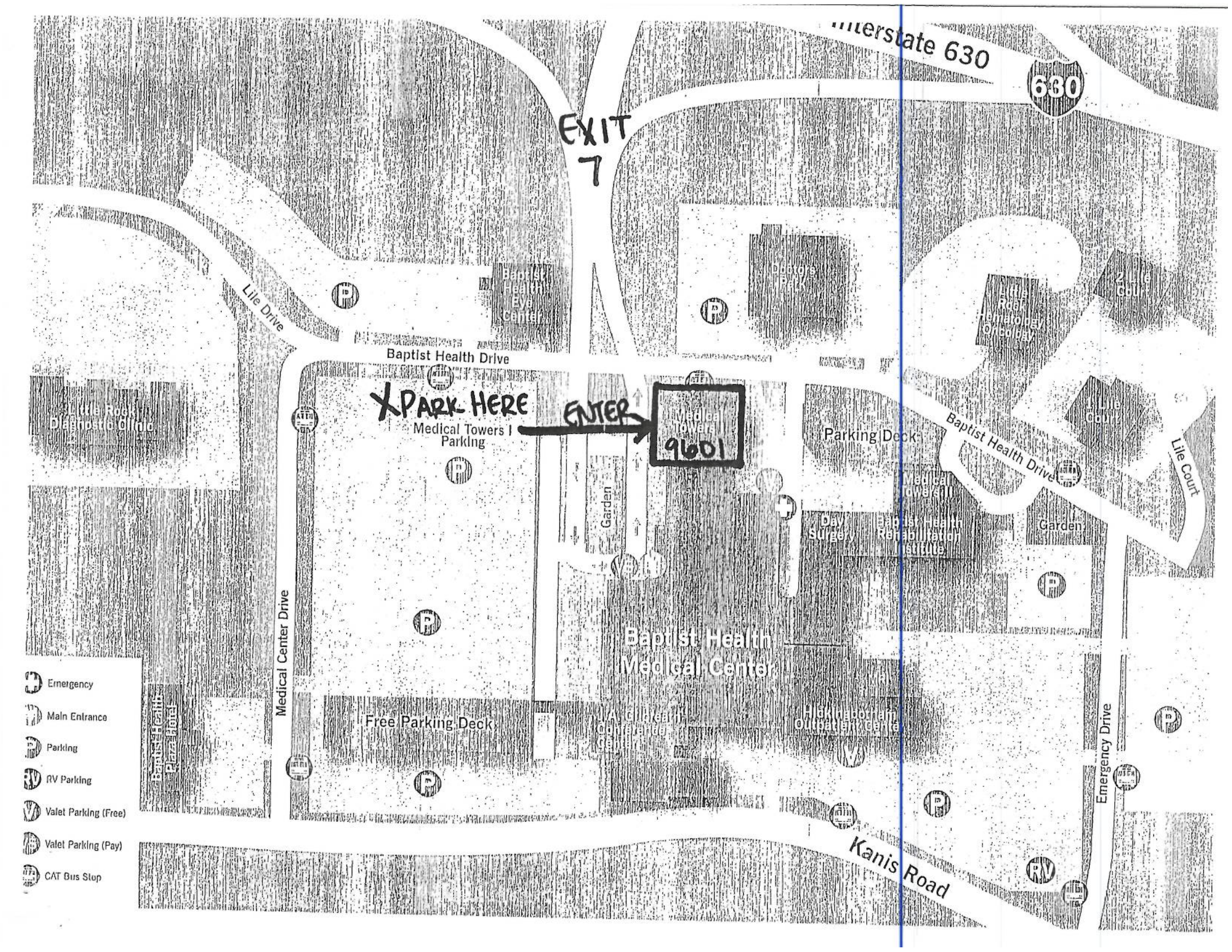
Under penalty of perjury, I swear that all information provided by me on this form is true to the best of my knowledge.

As the custodial parent, I authorize release of information on my child to the following: (please enter names of everyone who may receive information, such as non-custodial parent, step-parent, grandparents, attorney, physician, etc.)

_____

_____

_____ Date: _____
(Parent, Legal Guardian or Custodial Parent)


Interstate 630
630
EXIT 7
Lile Drive
Baptist Health Drive
X PARK HERE
Medical Towers I Parking
ENTER
Medical Towers II 9601
Parking Deck
Baptist Health Drive
Lile Court
Garden
Day Surgery
Baptist Health Rehabilitation Institute
Medical Center Drive
Baptist Health Medical Center
Free Parking Deck
Emergency Drive
Kanis Road
Emergency
Main Entrance
Parking
RV Parking
Valet Parking (Free)
Valet Parking (Pay)
CAT Bus Stop

PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

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Patient Name: _____ Social Security Number: ___-___-____

Date of Birth: ___/___/___ Sex: M / F (Circle one) Married / Single / Divorced / Widow

Language: _____ Race: _____ Ethnicity: Hispanic / Non-Hispanic / Other

Address: _____
(Street) (City/State/Zip)

Primary Phone: (___) _____-_____ Secondary Phone: (___) _____-_____

Would you be interested in having communications sent to you via your email? (examples: appointment reminders, administrative updates and health bulletins)

Yes No

Email: _____

Employer Name: _____ Phone: (___) _____-_____

Employer Address: _____
(Street) (City/State/Zip)

Primary Care Physician: _____ _____
(Name) (Phone)

How did you hear about our practice? _____

Pharmacy Name: _____
(Phone)

Person responsible for bill or parent/guardian *(Complete only if different from patient)*

Guarantor Name: _____ Social Security Number: ___-___-____

Relationship to Patient: (please check) ( ) self ( ) spouse ( ) parent Date of Birth: ___/___/___

Address: _____
(Street) (City/State/Zip)

Phone: (___) _____-_____ Email: _____

Employer Name: _____ Phone: (___) _____-_____

Employer Address: _____
(Street) (City/State/Zip)

Who to call for an emergency? *(Not at same address as patient)*

Name: _____ Relationship to Patient: _____

Primary Phone: (___) _____-_____ Secondary Phone: (___) _____-_____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Psychiatric Associates of Arkansas, PLLC. I further acknowledge that I am financially responsible for payment whether or not service is covered by my insurance policy.

_____ _____
Signature of Patient or Personal Representative Date

PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

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LITTLE ROCK, AR 72205

FINANCIAL POLICY (Pg 1 of 2)

Thank you for choosing us as your health care provider. The following is a statement of Financial Policy which we require you to read and sign prior to any treatment.

PAYMENT OF DEDUCTIBLES, CO-PAYMENTS AND ANY NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. NON-INSURED PATIENTS ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, AND DEBIT/CREDIT CARDS (MC, VISA, AMEX & DISC). THERE IS A $20 RETURNED CHECK FEE.

REGARDING INSURANCE

Your insurance coverage is a contract between you and your insurance company. If we are a contracted provider with your managed care company, we will handle your claims according to our agreement with your particular company. As a courtesy to you, we are happy to file your primary and secondary insurance. If you have more than two insurance companies, you will be responsible for filing the third insurance. **You are responsible for paying all deductibles, co-payments, and any non-covered services at the time of service.**

In the event we accept assignment of benefits, you are still ultimately responsible for all charges. **MEDICARE PATIENTS WILL HAVE A 20% COPAY (even though we take assignment).** Arkansas law requires insurance to pay within 45 days. We will not become involved in disputes with your insurance company. If they have not paid within this time frame, we will expect payment from you. Our practice is committed to providing the best treatment for our patients and we charge what are usual and customary rates. Our fees are as follows: New Patient Initial Evaluation = $200; Individual Psychotherapy = $165; Medication Management = $100; Family Therapy = $185; Group Therapy = $75. **Please note: There will be a charge of $200 per hour (billed in 15 minute increments) for filling out any FMLA, disability, or other paperwork if they are not done during an appointment. Prescriptions issued outside of appointments may be billed a $10 fee, depending upon the circumstances.**

MINORS

The adult accompanying a minor is responsible for full payment. This is regardless of any divorce decrees (which is a contract between parents; not between you and your doctor). If an ex-spouse is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the physician fees and then collect reimbursement from the ex-spouse. **PARENTS ARE RESPONSIBLE FOR SENDING CO-PAYMENTS WITH UNACCOMPANIED MINORS AT EACH VISIT. A parent or legal guardian must accompany a minor for their initial visit.**

DELINQUENT ACCOUNTS

I agree to be financially responsible for any unpaid balance due to Psychiatric Associates of Arkansas for services rendered. I understand that even though I have insurance, some diagnosis may not be covered under that insurance plan. If this occurs, I agree to pay the full fee for services.

I grant permission to Psychiatric Associates of Arkansas, its agents or assigns, to discuss my account with and release any information to any third party payer via the U.S. Postal Service, fax, or any electronic media in order to assist in the payment of any balance due, or otherwise verify personal information provided.

(continued on Pg 2)

PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

9601 BAPTIST HEALTH DRIVE, SUITE 1050

LITTLE ROCK, AR 72205

FINANCIAL POLICY (Pg 2 of 2)

Also, it is understood and agreed that Psychiatric Associates of Arkansas reserves the right to assess a monthly finance charge, in accordance with Arkansas Law, to any unpaid balance due. Further, it is agreed that should Psychiatric Associates of Arkansas determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I agree to pay any and all collection fees and costs expended to effect recovery, with such collection fees to be up to 50% of the unpaid balance due, including any and all attorney's fees assessed by any court.

APPOINTMENTS NOT CANCELED 24 HOURS IN ADVANCE ARE CHARGED A MISSED APPOINTMENT FEE OF $50 FOR MISSED INITIAL EVALUATION APPOINTMENTS AND $25 FOR MISSED DOCTOR FOLLOW-UP/MEDICATION MANAGEMENT APPOINTMENTS. PSYCHOTHERAPISTS ARE INDEPENDENT CONTRACTORS AND HAVE THEIR OWN MISSED APPOINTMENT POLICIES, WHICH THEY WILL DISCUSS WITH EACH PATIENT. ***Three missed appointments with no notification could result in dismissal from therapy!***

I UNDERSTAND I AM FULLY RESPONSIBLE FOR ANY OF THESE ABOVE MENTIONED FEES, AS THEY WILL NOT BE BILLED TO MY INSURANCE COMPANY!!

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING. WITH YOUR SIGNATURE YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF OUR FINANCIAL POLICY.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient

PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

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FINANCIAL POLICY (Pg 2 of 2)

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(Patient's Copy)

PSYCHIATRIC ASSOCIATES OF ARKANSAS

CONTROLLED SUBSTANCE CONTRACT

We are committed to doing all we can to treat your psychiatric illness. In some cases, benzodiazepines for anxiety or stimulants for the treatment of ADHD may be prescribed. These medications are strictly regulated by both state and federal guidelines. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for the proper controlled substance use.

1. All controlled substances have a potential for dependency and abuse.
2. Narcotics (pain pills) are not psychiatric medicines and we do not prescribe them.
3. All benzodiazepines or stimulants must come from the physician whose signature appears below, or during his/her absence, by the covering physicians unless specific authorization is obtained for an exception.
4. All controlled substances must be obtained from the same pharmacy, where possible. Should the need arise to change pharmacies our office must be informed. The pharmacy you have selected is _____, phone _____.
5. The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care for the purpose of maintaining accountability.
6. You may not share, sell, or otherwise permit others including spouse or family members to have access to these medications.
7. You agree to not consume excessive amounts of alcohol in conjunction with prescribed controlled substances. Additionally, you agree to not purchase, obtain or use any illegal drugs.
8. Unannounced urine drug screens may be requested and your cooperation required. Presence of unauthorized substances may result in your discharge from PAA.
9. Medications will not be replaced if they are lost, stolen, get wet, destroyed, left on an airplane, etc.
10. If the responsible legal authorities have questions concerning your treatment, as might occur if you were obtaining medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records.
11. Early refills will not be given. Renewals are based on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
12. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
13. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by PAA physicians.
14. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accept all its terms.
15. You agree to allow us access to your past prescriptions history.

Patient Name _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

PSYCHIATRIC ASSOCIATES OF ARKANSAS

Health Survey

Patient Name: _____ Pulse: _____

Height: _____ Weight: _____ Blood Pressure: Systolic _____ Diastolic _____

Smoker: Current _____ / Former _____ / Never _____

Please review the categorized list of symptoms below, and circle any and all that may apply to you.

1. General: fever, chills, sweats, appetite loss, fatigue, malaise, weight loss
2. Vision: blurring, double vision, irritation, discharge, vision loss, eye pain, light sensitivity
3. Ears/Nose/Throat: ear pain or discharge, ringing in ears, hearing loss, nasal obstruction/discharge, nosebleeds, sore throat, hoarseness, difficulty swallowing
4. Cardiovascular: chest pain, irregular heartbeat, fainting, shortness of breath, difficulty breathing, ankle swelling
5. Respiratory: cough, excess sputa, coughing up blood, wheezing, shortness of breath
6. Gastrointestinal: nausea, vomiting, diarrhea, constipation, changed bowel habits, abdominal pain, bloody stool, tarry stool, yellowing skin or eyes
7. Genitourinary: vaginal discharge, incontinence, painful urination, bloody or discolored urine, urinary frequency, vaginal bleeding, abnormal menstrual bleeding, abnormal menstrual pain, lack of menstrual periods, pelvic pain
8. Musculoskeletal: back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis
9. Skin: rash, itching, dryness, lesions
10. Neurologic: weakness, tingling, numbness, seizures, fainting, tremor, dizziness
11. Psychiatric: depression, anxiety, memory loss, paranoia, voices, suicidal ideation
12. Endocrine: cold intolerance, heat intolerance, excessive thirst, excessive urination, weight change
13. Hematologic/Lymphatic: bruising, bleeding, enlarged nodes
14. Allergic/Immunologic: rash, hay fever, repeated infections, HIV exposure

PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC
9601 Baptist Health Drive, Suite 1050, Little Rock, AR 72205
(501) 228-7400 phone – (501) 537-7412 fax

Date: _____

Referring physician: _____ Consent to send evaluation: Yes No

Consent for PAA to use e-prescribing for transmitting prescriptions to your pharmacy: Yes No

By signing I give consent or deny permission: _____
Parent/Legal guardian of child/minor

CHILD/MINOR ADMISSION DATABASE

Instructions to Parent/Guardian: Please fill this out as fully as you can comfortably. Don't labor over it; don't worry if you don't understand a part of it. An interviewer will go over and complete it with you.

1. Child's full name _____
2. Male _____ Female _____ Date of Birth _____ Age _____ Height _____ Weight _____
3. Biological mother's name _____ Phone _____
4. Biological father's name _____ Phone _____
5. Step-mother's name _____ Phone _____
6. Step-father's name _____ Phone _____
7. Custodial parents' name & phone number _____
   (Please include home, work & cell phone numbers) _____
   ****Please provide a copy of the court document naming the custodial parent.**

Please write briefly what problems your child is having and what you hope we can do to help.

_____

_____

_____

Has your child had any thoughts of suicide? Yes No

If yes, please explain: _____

Please place a check mark by any of the following your child has been having problems with:

____Difficulty sleeping	____Decreased appetite	____Increased appetite
____Loss of sense of humor	____Less ability to enjoy regular activities	
____Tearfulness	____Lack of concentration	
____Lowered self-esteem	____Less interest in bathing, washing hair, etc.	
____Isolation	____Withdrawal from family/friends	
____Irritability	____Loss of energy	

Are any of the following areas particularly stressful for your child? (Circle all that apply).

Relationships with parents Relationships with peers Health School

Legal problems Financial problems Family problems Death or Loss

Please explain:

_____

_____

_____

PSYCHIATRIC HISTORY

Has your child ever been treated for a psychiatric illness (depression, anxiety, ADHD, eating disorder, etc.)? Yes No

If yes, please list doctor's names, hospitals and dates of treatment:

_____

_____

_____

Has your child ever taken medicines for ADHD, depression, anxiety, or other mental illness? Yes No

If yes, please list the medicines: _____

_____

_____

Has your child had any of the following? (Circle your answer).

Neurological exam	Yes	No
Psychiatric exam	Yes	No
Psychological exam (or testing)	Yes	No
Professional counseling/psychotherapy	Yes	No

If you answered yes to any of the above, please list the names of the doctor or therapist:

_____

_____

If available, please bring copies of any evaluations or reports you may have on your child.

Please circle if your child has had problems with:

Generalized anxiety	Panic attacks	Anorexia or bulimia
Mania	Hearing voices	Obsessive thoughts and/or compulsive behavior

MEDICAL HISTORY

List the names of physicians your child has seen recently, what he/she saw them for and when:

_____

_____

What medicines does your child take regularly, what dosage and who prescribes them?

_____

_____

Has your child had any allergic reactions to medicines? Yes No

If yes, please list: _____

Does your child have any serious illnesses? Yes No

If yes, please list: _____

HABITS

Does your child smoke cigarettes? Yes No If yes, how much per day? _____

Does your child drink alcoholic beverages? Yes No

If yes, how often does your child drink? (Please circle whatever most closely applies to him/her).

Daily 1-2 times/week 3-5 times/week 1-3 times/month 1-3 times/six months 1-3 times/year

How much does your child drink at each event? _____

Has your child used drugs? (Crystal meth, cocaine, marijuana, etc.) Yes No

If yes, what drugs, how often, how much?

_____

_____

Has your child ever been in alcohol or drug treatment? Yes No

If yes, when and where?

_____

_____

Has your child ever suffered the consequences of drug or alcohol abuse such as legal problems (DWI, DUI, public intoxication, minor in possession of drugs, dealing drugs, etc.), medical problems (DT's, seizures, stomach problems, hepatitis, pancreatitis, AIDS, etc.), and/or social problems (trouble in school, loss of friends or family members, etc.)? Yes No

If yes, please explain: _____

_____

_____

FAMILY HISTORY

Was your child's pregnancy planned? Yes No

Were there any problems or complications during the pregnancy? Yes No

If yes, what problems? _____

Were any drugs or alcohol used during the pregnancy? Yes No

If yes, please explain: _____

At what age did your child take their first steps? _____ Say their first words? _____

Has your child ever been pregnant? Yes No N/A

If yes, please list the names and ages of children: _____

_____

Please list the names and ages of your child's brothers and sisters (including half & step siblings):

_____

_____

Do any of your child's brothers or sisters (including half & step siblings) have a problem with depression, anxiety or any other psychiatric illness? Yes No

If yes, who and what illness?

_____

_____

Do any of your child's brothers or sisters have a problem with drug or alcohol abuse? Yes No

Is your child's mother living? Yes No Is your child's father living? Yes No

Are they married to each other? Yes No

If divorced, how old was your child when they divorced? _____

Does your child's biological mother have a problem with any psychiatric illness? Yes No

Does your child's biological father have a problem with any psychiatric illness? Yes No

Does your child's biological mother have a problem with drug or alcohol abuse? Yes No

Does your child's biological father have a problem with drug or alcohol abuse? Yes No

If there are stepparents involved in the child's care, do any of them have a problem with either psychiatric illness or drug or alcohol abuse? Yes No

Do any of your child's biological relatives have a problem with psychiatric illness? Yes No

Do any of your child's biological relatives have a problem with drug or alcohol abuse? Yes No

Who lives in the child's home? _____

Who is the primary disciplinarian? _____

What are the usual methods of discipline? _____

Is your child adopted? Yes No

SOCIAL HISTORY

How would your child describe his/her childhood? Happy? Not happy? Why?

_____

_____

_____

Has your child suffered physical abuse? Yes No

If yes, by whom? _____

When did it occur? _____

Has it been reported? Yes No

If yes, by whom? _____

Has your child suffered sexual abuse? Yes No

If yes, by whom? _____

When did it occur? _____

Has it been reported? Yes No

If yes, by whom? _____

Is your child currently employed? Yes No N/A

If yes, where? _____

How long has he/she worked there? _____

What school does your child attend? _____ What grade? _____

How are his/her grades? _____ Conduct? _____

What kind of problems does he/she have in school? _____

_____

Does he/she have any learning disabilities? _____

Does he/she socialize well with peers? _____

Does he/she have any legal charges? _____

Please provide any other information the doctor needs to know in order to help your child.

_____

_____

_____