



ISLAND THERAPY SOLUTIONS

5030 Anchor Way, Suite 7

Christiansted, V.I. 00820

Phone: 340-719-7007

Fax: 340-719-6655

Thank you for choosing Island Therapy Solutions!

Please complete the following forms prior to your first appointment. You can send them via fax or email, or you can bring them with you to your scheduled appointment.

- Fax the forms to 340-719-6655
- Email to frontdesk@islandtherapysolutions.com

Required Forms Enclosed:

- Patient Information
- Cancellation Policy
- Financial Policy
- Informed Consent

CONFIDENTIAL
CHILD/ADOLESCENT INITIAL EVALUATION

PART I: PARENT/GUARDIAN INPUT:

Today's Date: _____

Child's Name: _____ Child's Social Security No. _____

Date of Birth: _____ Age: _____ yrs. _____ months Sex: M F

Race: _____ Ethnicity: _____

Person completing form: _____ Relationship: _____

Parent(s): _____ Legal Guardian: _____

Home Address: _____

Mailing Address _____

Email Address _____

Telephone number(s): (H) _____ (C) _____

Marital status of parents: Married Together Divorced Separated Single
 Widowed

Insurance Information:

Insurance Company: _____

Coverage Effective Date: _____ Ins. Contact Number: _____

Primary Card Holder Name: _____ DOB _____

Policy/Group Number: _____ Insured ID: _____

Address of Primary Card Holder if Different from Above: _____

Patient Relationship to Primary Card Holder: _____

Primary Cardholder's Employer: _____

PEOPLE WHO LIVE IN THE CHILD'S HOME:

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

OTHER FAMILY MEMBERS NOT LIVING WITH THE CHILD: (nannies, caregivers, etc.)

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____

What is your child's previous and current diagnoses, if any? _____

Is your child aware of the diagnoses? Y / N

What is the child's understanding of his/her diagnoses? _____

CHILD/ADOLESCENT'S CURRENT PSYCHIATRIC HISTORY:

Has your child received any psychiatric services or medications? Y N
(if not, please skip to the next section)

Psychiatrist(s) /date(s) started: _____

CURRENT MEDICATIONS :

<u>Name of med.</u>	<u>Dose</u>	<u>Times of day taken</u>	<u>Who prescribes</u>	<u>When started</u>	<u>lowest/highest dose ever taken</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has your child received previous psychological testing? ____ Yes ____ No

If yes: Where? _____ When? _____

*** Please bring a copy of the previous testing results with you.**

Psychologist/Therapist/Counselor: _____

Issues Addressed and Response to Treatment: _____

DEVELOPMENTAL HISTORY of your child:

Adopted? Y N Age at the time of Adoption: _____

Mother's age at child's birth _____

Any illness or complications during the pregnancy: _____

Did any of the following occur during the pregnancy?:

- smoking injury to the mother medications illegal drug use
 alcohol emotional stress other _____

BIRTH: Birth weight _____

Did any of the following occur during delivery/labor?

- emergency delivery trouble breathing incubator use
 C -section induced delivery (pitocin)

Child was born: Premature _____ weeks Full Term Late

INFANCY: Did any of the following occur?

- poor responsiveness excessive crying feeding problems
 difficult baby poor eye contact sleeping problems
 hard to comfort seemed not able to hear other

What was your infant's temperament? Easy going Irritable Passive Difficult to soothe Aggressive

TODDLER: Did any of the following occur?

- Did not start talking at 12-18 months Did not walk around 12 months of age
 Did not point to indicate interest in something Was not toilet trained by 3.5 yrs old
 Played with toys in unusual ways Never played "pretend"

CHILD'S EDUCATIONAL HISTORY

PRESCHOOL/DAYCARE AGE:

Preschool from age ____ to ____

Name of preschool or Early Intervention Program, if attended:

Any problems with adjustment, socialization or behavior? _____

Any other services? _____

Started Kindergarten/Primary School at what age? _____

Any testing conducted by the school?/what year? _____

Does your child have an IEP? _____ Receive special services? _____

Repeat any grades (which grade?) _____ Grades generally: A B C D F

Skipped any grades (which grade?) _____

Any adjustment/behavioral problems in any grade? _____

Has your child ever had tutoring? ____ Which subject (s)? _____

Please list in order all of the schools your child has attended:

Name of School	Grades Completed	Behavioral Conduct (Good, Fair or Poor)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILD'S BEHAVIORIAL HISTORY:

Is your child able to maintain friendships? _____

Problems with any of the following? **Starting at what age?**

- | | |
|--|--|
| <input type="checkbox"/> fighting ____ | <input type="checkbox"/> animal cruelty ____ |
| <input type="checkbox"/> legal problems ____ | <input type="checkbox"/> abused ____ |
| <input type="checkbox"/> running away ____ | <input type="checkbox"/> traumatized ____ |
| <input type="checkbox"/> alcohol ____ | <input type="checkbox"/> sexual activity ____ |
| <input type="checkbox"/> property destruction ____ | <input type="checkbox"/> lying ____ |
| <input type="checkbox"/> stealing ____ | <input type="checkbox"/> truancy ____ |
| <input type="checkbox"/> suspension ____ | <input type="checkbox"/> drugs ____ |
| <input type="checkbox"/> expulsion ____ | <input type="checkbox"/> frequent complaints from teacher(s) or
detentions ____ |
| <input type="checkbox"/> firesetting ____ | |

Choose the strategies used for dicipline:

- | | |
|--|---|
| <input type="checkbox"/> Time Out | <input type="checkbox"/> Take away something material (no cell phone) |
| <input type="checkbox"/> Send to room | <input type="checkbox"/> Grounding child |
| <input type="checkbox"/> Take away privilege (no TV) | <input type="checkbox"/> Yell at child |
| <input type="checkbox"/> Reason with child / negotiate | <input type="checkbox"/> Physical punishment |
| <input type="checkbox"/> Other _____ | |

Is the discipline effective? _____

CHILD'S MEDICAL HISTORY: (check all that apply)

___ allergy to medication(s) _____

___ started menstrual period Year/Age: _____ (if female) Date of LMP _____

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear infections | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> headaches |
| <input type="checkbox"/> stomach aches | <input type="checkbox"/> head injury | <input type="checkbox"/> chronic pain | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> heart problem | <input type="checkbox"/> liver problem | <input type="checkbox"/> kidney problem | <input type="checkbox"/> chronic diarrhea |
| <input type="checkbox"/> problems sleeping | <input type="checkbox"/> genetic testing | <input type="checkbox"/> vomiting | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> greater than "normal" weight gain | <input type="checkbox"/> greater than "normal" weight loss recently | | |
| <input type="checkbox"/> EEG | <input type="checkbox"/> brain imaging | <input type="checkbox"/> other special test(s) | |

other (specify) _____

serious accident(s): _____

hospitalization(s): _____

serious illness(es): _____

infectious disease(es) (e.g. HIV, TB, Hepatitis, Meningitis, etc.): _____

evaluation by neurologist (who/when): _____

Describe your child's regular diet (i.e favorite food / least favorite): _____

Do you have any concerns with their eating habits? _____

What is your child's typical bedtime and wake time? _____

Any concerns regarding your child's sleeping habits? _____

Pediatrician _____ Tel. # _____

FAMILY MEDICAL AND SOCIAL HISTORY:

Parent(s) occupation(s) Mother: _____ Father: _____

Current **stressors** relevant to the family:

- financial legal occupational deaths/losses
- housing safety recent birth/marriage abuse
- marital conflict violence illness/health care legal custody issues
- CYF (CYS) involvement: ___ current ___ in the past
- other stressor(s) _____

Please rate the overall level of family stress.

- Very Low Low Average High Very High

What is the greatest source of stress for the family? _____

Are any family members medically ill at present? _____

Any significant family medical history (seizures, heart problems, thyroid problems, genetic problems, etc.)?

Is your child involved in any of the following **social activities**?

- Sports _____
- Clubs _____
- Organizations _____
- Other _____

What are your child's **hobbies**? _____

What are your child's **strengths**?

FAMILY PSYCHIATRIC HISTORY:

Have any members of the child’s family had any of the following problems? Please indicate if maternal or paternal side.

<u>Problem</u>	<u>Family member(s)</u>	<u>Problem</u>	<u>Family member(s)</u>
<input type="checkbox"/> Anxiety _____		<input type="checkbox"/> Depression _____	
<input type="checkbox"/> Dementia/Alzheimers _____		<input type="checkbox"/> Bipolar/Manic _____	
<input type="checkbox"/> Schizophrenia _____		<input type="checkbox"/> ADHD _____	
<input type="checkbox"/> Learning problem _____		<input type="checkbox"/> Autism Spectrum _____	
<input type="checkbox"/> Intellectual Disability _____		<input type="checkbox"/> Speech problem _____	
<input type="checkbox"/> Alcohol abuse _____		<input type="checkbox"/> Drug abuse _____	
<input type="checkbox"/> Temper problem _____		<input type="checkbox"/> Abusive _____	
<input type="checkbox"/> Legal problems _____		<input type="checkbox"/> Personality Disorder _____	
<input type="checkbox"/> Other _____			

Has any family member been treated in a psychiatric hospital? Yes No

Who/When? _____

Has any family member attempted suicide? Yes No

Who/When? _____

Has any family member been institutionalized? Yes No

Who/When? _____

Has any of the family been in prison/jail? Yes No

Who/When? _____

Signature of Parent/Legal Guardian Completing this form

Date

Printed Name

Thank you for completing this form!

CANCELLATION POLICY

It is the intention of Dr. Lindsay Wagner, Dr. Wayne Etheridge, Dr. Dara Hamilton, Dr. Sophia Joseph-Parrilla, DeeAnne Davis, LCSW, Emma Rogers, LCSW, Dr. Adriane Maier and Dr. Natalie Williams to be flexible in meeting client and family needs. We have established the following cancellation policy that will hopefully be both flexible and reasonable as we work together to provide services. Our policy is based on the need to avoid unfilled appointments. This is especially important due to the number of families waiting to receive services. Therefore, our policy is as follows:

Cancellations must be made within 24 hours of the scheduled appointment time. The cancellation / no show fee is \$25 per missed appointment and is due at or prior to the next scheduled appointment.

The cancellation fee for our Psychiatrists, Dr. Rosalind Spells & Dr. Derek Spencer, is \$75 per missed appointment.

Our main office number is 340-719-7007. Once we receive notice from you, we will contact the appropriate staff members. We believe that we are offering a very important service and sincerely hope that you would not feel the need to cancel, except in case of illness or family emergency. We will also extend the same courtesy to you, in the event that our staff needs to cancel for the same or similar reasons.

Upon cancellation notification, our office staff will contact the family to re-schedule on the next available appointment date. Please keep in mind that the appointment may not be in the same month as the originally scheduled appointment.

It should also be mentioned that afterschool appointments are highly sought after. If your child has a standing afterschool appointment and they do not show up for the appointment or call to cancel, they will automatically lose that afterschool slot after 2 no show/cancelled appointments. They are welcome to reschedule in a slot that occurs during school hours.

Please feel free to contact us if you have any questions about this policy. We remain available to work with you in making the best possible use of this important service.

Client Name: _____ DOB: _____

Parent/Legal Guardian: _____ Date: _____

Child/Adolescent
(If 14 years of age or older): _____ Date: _____

Witness _____ Date: _____

FINANCIAL POLICY

Thank you for choosing Island Therapy Solutions as the health care provider for you. Our practice is committed to providing the best possible care for your children. It is vitally important to our professional relationship that you have a clear understanding of our financial policy. Please take a moment to review. We require that you **read, agree to and sign** our financial policy prior to any treatment.

CONTRACTED INSURANCE CO-PAYMENT/CO-INSURANCE/DEDUCTIBLE

Island Therapy Solutions participates with all insurances that are contracted with VI Equicare, Inc., and will file all charges incurred with the appropriate claims office. We have agreed to accept the rates from these plans, however all co-Insurance and co-payments are your responsibility and are payable at the time of service as per your contractual obligation with your insurance company. Island Therapy Solutions is contractually obligated to collect this co-payment at the time of service. Island Therapy Solutions will collect in full any amount incurred per visit until your deductible is met.

Today's health insurance policies and coverage offers more options than ever. Each patient is responsible for knowing his/her plan benefits package, co-payment, co-insurance deductible, non-covered services and restrictions.

NON-CONTRACTED INSURANCES

If you do not participate with your insurance plan, payment in full is expected at the time of service. We will provide you with a claim form for filing with your insurance company.

SECONDARY INSURANCE

Have more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance has cleared.

NO INSURANCE

Full payment is due at the time of service. If you are unable to pay your balance in full, please make arrangements with our billing department prior to your scheduled appointment. Failure to make prior arrangements for payment, thus requiring us to bill the visit fee will result in additional fees (*please see below*).

PAYMENT/SERVICE CHARGE FEES

We accept cash, bank certified check, debit and credit cards with the Visa and MasterCard logo.

In the event that there are any outstanding payments after service is performed there will be a service charge fee of \$30.00 if payment is not made by the end of the business day.

There will be a \$50.00 service charge for all returned checks.

Any outstanding balances are due within 30 days. If you are experiencing circumstances out of your control, please call our office and we will be happy to make payment arrangements. All accounts with unpaid balances over 60 days will be assessed a \$30.00 monthly statement fee. All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency you will be financially responsible for any collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Thank you for your understanding of our financial policy. If you have any questions or concerns, please feel free to discuss them with our billing department.

I have read and fully understood the Financial Policy of Island Therapy Solutions.

Print Name

Date

Signature

Date

