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

ADULT INITIAL EVALUATION

PART I: PATIENT INPUT:

Today's Date: _____

Patient's Name:_____ Social Security No._____

Date of Birth: _____ Age: _____ Sex: ☐M ☐ F

Race: _____ Ethnicity: _____

Home Address: _____

Mailing Address _____

Email Address _____

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

Marital status: ☐ Married ☐ Together ☐ Divorced ☐ Separated ☐ Single ☐Widowed

Employer: _____ Phone: _____

INSURANCE INFORMATION:

Insurance Company: _____

Coverage Effective Date: _____ Ins. Contact Number: _____

Primary Card Holder Name: _____ DOB _____

Policy/Group Number: _____ Member ID: _____

Address of Primary Card Holder if Different from Above: _____

Patient Relationship to Primary Card Holder: _____

Primary Cardholder's Employer:_____

What are your current living conditions? Check all that apply

☐ Alone ☐ With Spouse / Partner ☐ With Roommate
☐ With Children ☐ With Family

PEOPLE WHO LIVE IN THE HOME:

Name	Age	Relationship	Name	Age	Relationship

Are you satisfied with your living arrangements? ☐ Yes ☐ No

Please describe why you wish to be seen for an appointment and the problem(s) or symptom(s) you are currently having:

_____

_____

_____

_____

_____

What are some of your strengths? _____

_____

_____

What would you like to accomplish in counseling? List any goals. _____

_____

_____

_____

PREVIOUS MENTAL HEALTH TREATMENT

Outpatient Counseling: ☐Yes ☐ No Dates: _____

Provider/Program_____

Reason for Treatment_____

Medications: _____

Medication (Mental Health): ☐Yes ☐ No Dates: _____

Provider/Program_____

Reason for Treatment_____

Medications: _____

Psychiatric Hospitilization: ☐Yes ☐ No Dates: _____

Provider/Program_____

Reason for Treatment_____

Medications: _____

Drug/Alcohol Treatment: ☐Yes ☐ No Dates: _____

Provider/Program_____

Reason for Treatment_____

Medications: _____

Self-Help/Support Group: ☐Yes ☐ No Dates: _____

Provider/Program_____

Reason for Treatment_____

Medications: _____

Patient's **DEVELOPMENTAL HISTORY**

BIRTH: Birth weight_____

Did any of the following occur during delivery/labor?

☐ emergency delivery ☐ trouble breathing ☐ incubator use

☐ C -section ☐ induced delivery (pitocin) ☐premature

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

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"

Patient's **MEDICAL HISTORY:** (check all that apply)

___ allergy to medication(s) _____

☐ asthma ☐ ear infections ☐ seizures/epilepsy ☐ headaches
☐ stomach aches ☐ head injury ☐ chronic pain ☐ diabetes
☐ heart problem ☐ liver problem ☐ kidney problem ☐ chronic diarrhea
☐ problems sleeping ☐ genetic testing If yes, when? _____
☐ vomiting ☐ loss of consciousness
☐ greater than "normal" weight gain ☐ greater than "normal" weight loss recently
☐ EEG ☐ brain imaging ☐ other special test(s) _____
☐ Vision problems (glasses/contacts) ☐ hearing problems (specify)_____

☐ other (specify)_____

☐ serious accident(s): _____

☐ hospitalization(s): _____

☐ serious illness(es): _____

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

☐ evaluation by neurologist (who/when): _____

Are you having problems with your sleep habits? ☐ Yes ☐ No If yes, please describe:

_____

_____

Are you having difficulty with appetite / eating habits? ☐Yes ☐ No

If yes, check where applicable: ☐ Eating less ☐Eating more ☐Binging ☐Restricting
☐ Other _____

_____

_____

Patient's **SOCIAL HISTORY**

EMPLOYMENT

Employer: _____

Length of time in this position: _____ Job Duties: _____

Stress level of this position: ☐Low ☐Medium ☐ High

Other jobs you have held: _____

_____

EDUCATION

Are you currently attending school? ☐ Yes ☐ No If yes, where _____
What are you studying? _____

☐High School Graduate or ☐ GED Year _____
☐Associate's Degree Year _____ Major are of study _____
☐Undergraduate Degree Year _____ Major area of study_____
☐Graduate Degree Year _____ Major area of study _____

MILITARY SERVICE

Have you been / are you currently in the military? ☐Yes ☐ No

Branch _____ Date of Discharge _____

Type of Discharge_____ Rank_____

Were you in combat? ☐ Yes ☐ No

LEGAL

Have you ever been convicted of a misdemenor or felony? ☐Yes ☐ No If yes, please explain_____

_____

_____

Are you currently involved in any divorce or child custody proceedings? ☐Yes ☐ No If yes, please explain _____

_____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional Abuse	☐ Neglect	☐ Lived in a foster home
☐ Sexual Abuse	☐ Violence in the home	☐ Multiuple family moves
☐ Physical Abuse	☐ Crime victim	☐ Homelessness
☐ Parent substance abuse	☐ Parent illness	☐ Loss of aloved one
☐ Teen pregnancy	☐ Placed a child for adoption	☐ Financial problems

Patient's **SUBSTANCE USE HISTORY**

Alcohol ☐Yes ☐No
Current Use (last 6 months): Frequency☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency ☐Daily ☐Weekly ☐Monthly Amount:_____

Caffeine ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency ☐Daily ☐Weekly ☐Monthly Amount:_____

Cocaine / Crack ☐Yes ☐No
Current Use (last 6 months): Frequency☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency ☐Daily ☐Weekly ☐Monthly Amount:_____

Ecstasy ☐Yes ☐No
Current Use (last 6 months): Frequency☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency ☐Daily ☐Weekly ☐Monthly Amount:_____

Heroin ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency ☐Daily ☐Weekly ☐Monthly Amount:_____

Inhalants ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency ☐Daily ☐Weekly ☐Monthly Amount:_____

Marijuana ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

Methamphetamines ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

Pain Killers ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

PCP / LSD ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

Steroids ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

Tobacco ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

Tranquilizers ☐Yes ☐No
Current Use (last 6 months): Frequency ☐Daily ☐Weekly ☐Monthly Amount: _____
Past Use: Frequency☐Daily ☐Weekly ☐Monthly Amount:_____

Have you had withdrawal symptoms when trying to stop using any substances? ☐Yes ☐ No
If yes, please describe _____

_____

_____

_____

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe**:** _____

_____

_____

_____

FAMILY MEDICAL AND SOCIAL HISTORY:

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
☐trauma ☐ 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? _____

Family Circumstances: ☐ My parents are married ☐ My parents are divorced / separated.

☐Other _____

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

_____

_____

Have you received previous psychological testing? ☐Yes ☐ No

If yes, Where? _____ When? _____
*Please bring a copy of previous testing results with you.

FAMILY PSYCHIATRIC HISTORY:

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

Problem	Family member(s)	Problem	Family member(s)
☐ Anxiety		☐ Depression	
☐ Dementia/Alzheimers		☐ Bipolar/Manic	
☐ Schizophrenia		☐ ADHD	
☐ Learning problem		☐ Autism Spectrum	
☐ Intellectual Disability		☐ Speech problem	
☐ Alcohol abuse		☐ Drug abuse	
☐ Temper problem		☐ Abusive	
☐ Legal problems		☐ Personality Disorder	
☐ 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 Patient/Legal Guardian Completing this form Date

_____

Printed Name

Thank you for completing this form!

CANCELLATION POLICY

It is the intention of Dr. Lindsy 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 is 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

ISLAND THERAPY SOLUTIONS

CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Client Name:_____ Date of Birth:____/____/_____
(Last) (First) (Middle)

Home Address:_____

I understand that any of my personal health information (other than notes from any therapy sessions with a counselor) may be used and/or disclosed by Island Therapy Solutions for purposes of carrying out treatment, obtaining payment, and carrying out other health care operations of the organization. I have received a copy of Island Therapy Solutions' Notice of Privacy Practices, which I understand provides a more complete description of possible uses and disclosures of my health information. I understand that it is my right to review the Notice of Privacy Practices prior to signing this consent form. I also understand that the terms of the Notice of Privacy Practices may change in the future and that I may obtain a copy of the Notice of Privacy Practices that is in effect at any given time (whether or not it has ever been changed) by requesting a copy at the front desk.

I understand that I have a right to request how my health information is used or disclosed to carry out treatment, payment or other health care operations, but I also know that Island Therapy Solutions is not required to agree to any such request. I understand that, if Island Therapy Solutions agrees to my request, the restriction will be binding on Island Therapy Solutions.

I understand that I have a right to revoke this consent by filling out and signing a written revocation form which is available at the front desk, from the Office Manager. I also understand that, if I choose to revoke my consent, it can only be revoked to the extent that Island Therapy Solutions has not acted in reliance upon the consent.

By signing below, I hereby voluntarily and knowingly consent to allow Island Therapy Solutions and any of its physicians, counselors, employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment and/or other health care operations of the organization.

Dated:_____ _____
(Signature of Client or Legal Representative)

If you are the legal representative of the client, please check off the basis for your authority:

- ☐ Power of Attorney (attach copy)
- ☐ Guardianship Order (attach copy)
- ☐ Parent of Minor
- ☐ Other_____