



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 Hospitalization: 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?

- | | | |
|---|---|--|
| <input type="checkbox"/> emergency delivery | <input type="checkbox"/> trouble breathing | <input type="checkbox"/> incubator use |
| <input type="checkbox"/> C -section | <input type="checkbox"/> induced delivery (pitocin) | <input type="checkbox"/> premature |

INFANCY: Did any of the following occur?

- | | | |
|--|--|--|
| <input type="checkbox"/> poor responsiveness | <input type="checkbox"/> excessive crying | <input type="checkbox"/> feeding problems |
| <input type="checkbox"/> difficult baby | <input type="checkbox"/> poor eye contact | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> hard to comfort | <input type="checkbox"/> seemed not able to hear | <input type="checkbox"/> 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) _____

- | | | | |
|---|--|---|---|
| <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 If yes, when? _____ | | |
| <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) _____ | |
| <input type="checkbox"/> Vision problems (glasses/contacts) | | <input type="checkbox"/> hearing problems (specify) _____ | |

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): _____

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 misdemeanor 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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Neglect | <input type="checkbox"/> Lived in a foster home |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Multiple family moves |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Crime victim | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Parent substance abuse | <input type="checkbox"/> Parent illness | <input type="checkbox"/> Loss of loved one |
| <input type="checkbox"/> Teen pregnancy | <input type="checkbox"/> Placed a child for adoption | <input type="checkbox"/> 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.

<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 Patient/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, Carla S. Perkins, LCSW, Dr. G. Rita Dudley-Grant, Dr. Adriane Maier, Daniel Kurty and our Counseling Interns 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. Ernest Jermin & 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

