ISLAND THERAPY SOLUTIONS
5030 Anchor Way, Suite 7, 9 & 10
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: ___________________

Client's Name:______________________________ Client's Social Security No.______________

Date of Birth: ____________________ Age: _____ yrs. ______months

Race: ___________________________ Ethnicity: _____________________________

CONTACT INFORMATION

Parent(s):____________________________________ Legal Guardian:___________________________

Home Address: ____

Mailing Address ____

Email Address ____

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

(W)___________________________ (O)____________________________

Emergency Contact: ____

GENDER

1. What is the client's current gender identity? (Check and/or circle ALL that apply)

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM

☐ Transgender Female/Transwoman/MTF ☐ Genderqueer

☐ Additional category (please specify): _____________________ ☐ Decline to answer

2. What sex was assigned at birth? (Check one)
☐ Male ☐ Female ☐ Decline to answer

3. What pronouns does the client prefer? ____
He/Him; She/Her; They/Them

INSURANCE

Primary Insurance Company: ____

Coverage Effective Date: __________ Ins. Contact Number: ____________________

Primary Card Holder/Guarantor Name: ___________________ DOB ___________

Policy/Group Number: ___________ Insured ID: _________________________

Address of Guarantor if Different from Above: _______________________________

____

Patient Relationship to Guarantor: _______________________________

Guarantor's Employer:_______________________________________

Secondary Insurance Company: ____

Coverage Effective Date: __________ Ins. Contact Number: _________________

Guarantor's Name: ___________________ DOB ________________

Policy/Group Number: ___________ Insured ID: _______________________

Address of Guarantor if Different from Above: _______________________________

Patient Relationship to Guarantor: _______________________________

CUSTODY AND LIVING ARRANGEMENTS

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

Any prior, existing, ongoing or anticipated divorce or child custody proceedings? ☐ Yes ☐ No

If yes, what was the outcome relative to custody of the child.______________________

Provide legal documents relative to custody or legal guardianship of the child.

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.)

__________ ____ __________ __________ ____ __________

__________ ____ __________ __________ ____ __________

CLIENT'S EDUCATION HISTORY

Current School: ______________________________ Current Grade: __________

Placement: ☐ Regular classes ☐ Learning Support ☐ Emotional Support
☐ Autistic Support ☐ Gifted ☐ Full time ☐ Part time

Child's attitude toward school: ____

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)

CLIENT'S DIAGNOSTIC HISTORY

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 :

Name of Med / Dose / Times of Day Taken / Who prescribes / When started /Lowest & Highest Dose EverTtaken

____

____

____

____

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: ____________________________________

____

____

____

____

____

____

____

____

____

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

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 ☐zika ☐ 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 @________weeks

INFANCY: Did any of the following occur?

☐ poor responsiveness ☐ excessive crying ☐ feeding problems

☐ flat head ☐ poor eye contact ☐ sleeping problems

☐ hard to comfort ☐ seemed not able to hear ☐ jaundice

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 BEHAVORIAL HISTORY

Is your child able to maintain friendships? ____

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

☐ fighting ___
☐ suspension ____
☐ expulsion ____
☐ animal cruelty ____
☐ sexual activity ____
☐ drugs ____
☐ stealing ____
☐ property destruction ____
☐ alcohol ___
☐ abused ____
☐ lying ____
☐ frequent complaints from teacher(s) or detentions ____
☐ legal problems ___
☐ running away ____
☐ firesetting ____
☐ traumatized ____
☐ truancy ___

Choose the strategies used for dicipline:

☐Time Out
☐Send to room
☐Take away privilege (no TV)
☐Reason with child / negotiate
☐ Take away something material (no cell phone)
☐Grounding child
☐ Yell at child
☐Physical punishment
☐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 _______

☐ 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 ☐ vomiting ☐ loss of consciousness

☐ greater than "normal" weight gain ☐ greater than "normal" weight loss recently

☐ EEG ☐ brain imaging ☐ other special test(s)

☐ other (specify)____

☐ serious accident(s): ____

☐ hospitalization(s): ____

☐ serious illness(es) (e.g. dengue fever, zika, etc.): ____________________________________

☐ infectious disease(es) (e.g. HIV, TB, Hepititis, 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 ____ Telephone #____________________

CHILD'S SOCIAL HISTORY

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 MEDICAL AND SOCIAL HISTORY

Mother's Occupation:______________________ Father's Occupation :____________________
Current **stressors** relevant to the family:

☐ financial	☐ legal	☐ occupational	☐ deaths/losses
☐ housing	☐ safety	☐ recent birth/marriage	☐ abuse
☐ marital conflict	☐ violence	☐ illness/health care issues	☐ legal custody

☐ 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? ________________________

Are any family members medically ill at present? ________________________

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

____

FAMILY PSYCHIATRIC HISTORY:

Have any members of the child's family 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 Parent/Legal Guardian Completing this form Date

____

Printed Name

Thank you for completing this form!

<u>CANCELLATION POLICY</u>

effective May 2019

It is the intention of all providers of Island Therapy Solutions 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 late cancellation / no show fee for psychotherapy or counseling services is $25 per missed appointment.

The late cancellation / no show fee for psychiatric services is $75 per missed appointment.

The late cancellation / no show fee for testing is $25 per scheduled hour.

All late cancellation / no shows fees are due at or prior to the clients next scheduled appointment, with any provided within our organization.

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.

If a client has a standing appointment and they fail to show up for the appointment or call to cancel in a timely manner, they will automatically be removed from the schedule after 2 such occurrences in a 4-week period. The client may be placed back on the schedule once all applicable no show fees are paid. It is the client's responsibility to contact our office to be placed back on the provider's schedule.

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_______________________

Today's Date: ____________________

I have been a patient at Island Therapy Solutions before today: (circle one) Yes No

How did you hear about us?

Please check all that apply.

- ☐ **Friend/Family**:
- ☐ **Facebook**
- ☐ **Website**
- ☐ **Internet Search**
- ☐ **Professional Referral: Please specify**__________________________________
- ☐ **Phonebook**
- ☐ **Billboard**
- ☐ **Newspaper**
- ☐ **Walked By**
- ☐ **Radio**
- ☐ **Community Event: Please specify**__________________________________
- ☐ **Other**___________________________