PARK CITIES PSYCHIATRY

Sandra Lotan, M.D.
Board Certified Adult, Child &
Adolescent Psychiatry

Regina McFarland, M.D.
Board Certified Adult, Child &
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OFFICE POLICY LETTER

- The receipt that we provide is designed to provide information required by insurance companies. You will be responsible for filing your claims with the insurance carrier.
- We do not disclose any information with your insurance without your knowledge.
- We do not share any patient information with 3'd parties, without your consent.
- In case of an emergency, call 911 or proceed to your nearest Emergency Room. If your child is in crisis and you call after hours, cell phone numbers are provided on our answering machine.

HIPAA STATEMENT

All issues discussed in the course of treatment are strictly confidential with the following exceptions:

1. Consultation with other current healthcare providers if pertinent to treatment.
2. Instances in which the patient maybe-an imminent threat to self or others, unable to care for his or her most basic needs, or in cases of suspected child abuse.
3. Consultation with a colleague.
4. Under certain circumstances when ordered by court.
5. Some treatment information such as name, diagnosis, date of service and charge provided to insurance companies to facilitate reimbursement. This is done at your discretion.

Should you request that specific information be released to other healthcare professionals, school staff or anyone else, you will be asked to sign a consent form for the release of this information.

Please sign below acknowledging that you have read and understand our office policies.

_____

Parent or Guardian
Patient – if age 18 or older

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Child Forms

Child's Name: _____ DOB: _____ Sex: _____

Child's School: _____ Grade Level: _____

Contact number for messages or reminder calls: _____

Email Address: _____

Father: _____ DOB: _____ Religion: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Mobile #: _____

Occupation: _____ Work #: _____

Previous Marriages: _____ Ended: _____

Mother: _____ DOB: _____ Religion: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Mobile #: _____

Occupation: _____ Work #: _____

Previous Marriages: _____ Ended: _____

Children in order of their birth including the child referred:

1) _____ (DOB: _____) 3) _____ (DOB: _____)

2) _____ (DOB: _____) 4) _____ (DOB: _____)

Others in Household: _____

List Name and Addresses of Previous Therapists or Testers:

1) _____

2) _____

3) _____

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Pediatrician/Family Doctor: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

Preferred Pharmacy Name: _____ Phone #: _____

Address: _____ City: _____ Zip: _____

Referred By: _____

Parent Signature: _____ Date: _____
(Patient signature if over 18 years of age)

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Past Medical History

Please mark any that the patient has or has had in the past.

- ○ Head injury/ Loss of consciousness
- ○ Seizures/ Convulsions
- ○ Other neurological problems
- ○ Ear, Nose, or throat problems
- ○ Dental problems
- ○ Asthma
- ○ Chest problems
- ○ Stomach or bowel problems/ soiling
- ○ Urinary or bladder/ wetting
- ○ Heart problems
- ○ Rheumatic fever/ strep infections
- ○ Liver/ Kidney problems
- ○ Skin problems
- ○ Joint/ limb problems
- ○ Hearing/ vision problems
- ○ Growth/ endocrine problems
- ○ Gynecological/ menstrual problems
- ○ Childhood measles/ mumps

Has any family member had any of the following? *Please indicate which family member.*

- ○ Depression
- ○ Mania/ Bipolar Disorder
- ○ Suicidal thoughts/ Urges/ Behaviors
- ○ Anxiety
- ○ Panic
- ○ Obsessions/ Compulsions
- ○ Rituals
- ○ Movement Disorders
- ○ Tics
- ○ Unusual noises/ vocalizations
- ○ ADHD
- ○ Eating Disorders
- ○ Learning Disability
- ○ Coordination problems
- ○ Mental Retardation
- ○ Autism/ Asperger's Disorder/ PDD
- ○ Sleep Disorder
- ○ Drug use
- ○ Alcohol use
- ○ Psychosis
- ○ Legal Problems
- ○ Psychiatric hospitalizations
- ○ Other: _____

Please elaborate on the above as needed: _____

_____

_____

_____

Please provide information about significant medical issues on the FATHER'S side: _____

_____

_____

Please provide information about significant medical issues on the MOTHER'S side: _____

_____

_____

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ADHD Checklist

0 = Not a problem 1 = Mild 2 = Moderate 3 = Severe

Learning Skills:

____ Reading
____ Writing
____ Spelling
____ Qualitative Reasoning
____ Math Calculating
____ Processing Speed
____ Memorizing
____ Concentrating
____ Listening
____ Other: _____

Please score the following symptoms from 0-3:

Inattention:

____ Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
____ Often has difficulty sustaining attention in tasks or play activities
____ Often does not seem to listen when spoken to directly
____ Often does not follow through on instructions and details to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
____ Often his difficulty organizing tasks and activities
____ Often avoids, dislikes, or is reluctant to engage in tasks (such as schoolwork or homework) that required sustained mental effort
____ Often loses things necessary for task and activities (e.g., school assignments, pencils, books, tools, etc.)
____ Is often easily distracted by extraneous stimuli
____ Often forgetful in daily activities

Hyperactivity:

____ Often fidgets with hands or feet or squirms in seat
____ Often leaves (or greatly feels the need to leave) seat in classroom or in other situations in which remaining seated is expected
____ Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
____ Often has difficulty playing or engaging in leisure activities that are more sedate
____ Is often "on the go" or often acts as if "driven by a motor"
____ Often talks excessively

Impulsivity:

____ Often blurts our answers before questions have been completed
____ Often has difficulty waiting turn
____ Often interrupts or intrudes on others (e.g., butts into conversations or games)

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Consent for Child Treatment

I am the parent/legal guardian of _____ with full legal authority to consent to treatment. I give permission for Park Cities Psychiatry to provide treatment for this child which may include assessment, advocacy, referral and mental health counseling.

Signature: _____ Date: _____

Print name: _____ Relationship to child: _____

Type(s) of service desired: { } Child therapy { } Adolescent therapy { } Family therapy

{ } Referral for medication evaluation

Child's main problem/major reason for seeking helping at this time: _____

_____

_____

_____

How long has your child had these problems, symptoms, or issues? _____

_____

_____

_____

Has your child had treatment for these issues in the past? { } Yes { } No

If Yes, was the outcome helpful? { } Yes { } No

Has your child had inpatient mental health treatment? { } Yes { } No

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Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

_____

_____

_____

_____

Describe any other behavioral or emotional problems your child is having: _____

_____

_____

_____

_____

Describe the impact of your child's problems on the family: _____

_____

_____

Describe your child's strengths and unique qualities: _____

_____

_____

_____

Is your child currently under the care of a physician or psychiatrist? { } Yes { } No

If yes: Doctor's Name: _____ Phone #: _____

Treatment for: _____

_____

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Is your child currently taking any medications? { } Yes { } No If yes, include the following information:

Name of Medications	Dosage	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No

If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/ family: _____

_____

_____

_____

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BEHAVIOR CHECKLIST Please check any of the following behaviors that concern you:

Behavior:	Current	Past	Behavior:	Current	Past
Crying, sadness, depression			Temper outbursts		
Loss of enjoyment of usual activities			Irritability, anger		
Expressing a wish to die			Argues a lot		
Bedtime fears, won't sleep			Disobedience		
Has threatened/attempted suicide			Does things that annoy others		
Worries more than others			Unusual fears or phobias		
Panics			Anxious, nervous		
Repeats unnecessary act over and over			Is overly concerned about things		
Has rituals, habits, superstitions			Twitches or unusual movements		
Eats very little/fasts to lose weight			Gorges or binge eats		
Sleepwalking			Blames others for own mistakes		
Withdrawn			Easily annoyed by others		
Nightmares, night terrors			Swears or uses obscene language		
Low self-esteem			Wanting to run away		
Wakes up very early, unable to go back to sleep			Sneaks out at night		
Tiredness, fatigue			Injures self		
Restless sleep, wakes frequently			Stealing		
Trouble going to sleep			Lying		
Sleeps too much			Hurts animals		
Poor appetite			Destroys property		
Under or overweight			Hurts people		
Over-activity			Drug use		
Frequently acts without thinking			Alcohol use		
Doesn't finish things			Cigarette use		
Disruptive			Sexual problems		
Short attention span			Problems with authority		
Daydreams, fantasizes			Problems with the law		
Easily distracted			Low motivation		
Hallucinations			Vomits intentionally		
Bedwetting/daytime wetting			Soiling (pooping) in pants		
Strange or unusual behavioral			Disorientation		

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Forms of discipline used in the home: { } Time out { } Loss of privileges { } Grounding

{ } Rewards/incentives { } Extra chores { } Physical/corporal punishment

{ } Other: _____

Relationship Development Check each item that describes your child:

Behavior:	Current	Past	Behavior:	Current	Past
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem kids"			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is oversensitive			Conflict with parents/step-parents		
Poor relationships with teachers			Has difficulty getting along with siblings		

School Check any area of concern:

Behavior:	Current	Past	Behavior:	Current	Past
Dislikes school			Missed many school days		
Works hard but does not do well			Repeated a grade		
Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning problems			Suspensions (how many? _____)		
Expulsions (how many? _____)					

If your child has been suspended or expelled, please explain: _____

_____

_____

_____

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School Environment Check all that apply:

	Current	Past		Current	Past
Resource classes/special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Independent study		
Other programs					

If other stressors, please describe: _____

_____

_____

_____

Family Stresses Check all that apply:

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other stressors:		

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FEE POLICY

Payment for service is due at the completion of each visit. Cash, personal check, or credit card (Visa or Mastercard) is accepted.

We charge for missed appointments or appointments cancelled with less than 24 hours notice.

Initial Session	(90 minutes)	$575
Full Session	(55 minutes)	$300
Half Session	(25 minutes)	$200
School Visit		$325
Prescriptions-Controlled Substance		$25
Prescriptions-Other		no charge
School Letters for SAT, ACT, or special accommodations		$250

_____ _____

Signature of Responsible Party Date

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CONSENT FOR RELEASE OF INFORMATION
For Sandra Lotan M.D.

_____ _____
Named Patient (Please Print) Patient's Date of Birth

(Please initial all that apply)

_____ I authorize **Sandra Lotan, M.D.** to **release** records to the named practitioner/office/individual.

_____ I authorize **Sandra Lotan, M.D.** to **request** assessments and/or records for the named client from the named practitioner I office/individual.

_____ I **authorize Sandra Lotan, M.D.** to **consult** with the named practitioner/person for the client named below.

_____
Named Practitioner/Office/Person

_____
Address, City, State & Zip code

_____ _____
Office Phone Office Fax

_____
Email Address

_____ _____
Signature of Patient/Guardian Date

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CONSENT FOR RELEASE OF INFORMATION
For Regina McFarland M.D.

_____ _____
Named Patient (Please Print) Patient's Date of Birth

(Please initial all that apply)

_____ I authorize **Regina McFarland, M.D.** to **release** records to the named practitioner/office/individual.

_____ I authorize **Regina McFarland, M.D.** to **request** assessments and/or records for the named client from the named practitioner I office/individual.

_____ I authorize **Regina McFarland, M.D.** to **consult** with the named practitioner/person for the client named below.

_____
Named Practitioner/Office/Person

_____
Address, City, State & Zip code

_____
Email Address

_____ _____
Office Phone Office Fax

_____ _____
Signature of Patient/Guardian Date